Cambodia

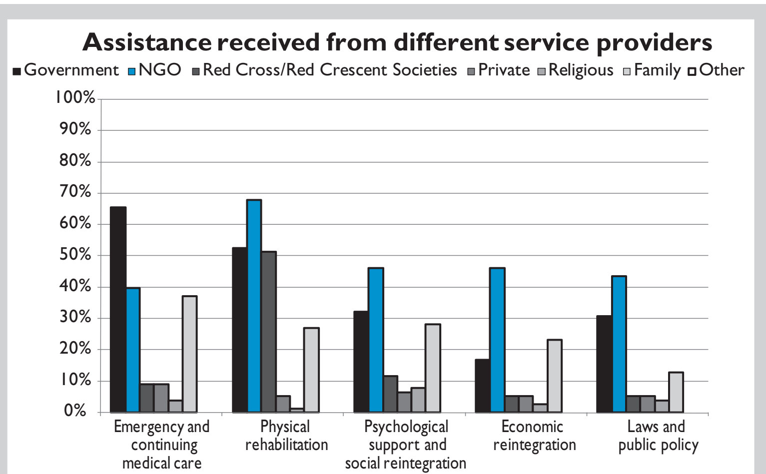
Country indicators

- *Conflict period and mine/ERW use:* Cambodia is severely contaminated by mines, cluster submunitions and ERW as a result of three decades of conflict (used by Vietnam, the Cambodian army, Cambodian guerilla forces and the US).[1]
- *Estimated contamination:* As of May 2009, some 3,867km^2 of land was estimated to remain contaminated, affecting 122 districts; 672km^2 needed full clearance. However, these figures were considered to be exaggerated as current data "presents a suspect area that all in the sector know is a massive, inaccurate and distorting snapshot."[2]
- *Human development index:* 131st of 179 countries, medium human development (compared to 130th of 177 in 2004).[3]
- *Gross national income (Atlas method):* US$600 – 182nd of 210 countries/areas (compared to US$330 in 2004).[4]
- *Unemployment rate:* 3.5% (compared to 2.5% in 2004).[5]
- *External resources for healthcare as percentage of total expenditure:* 22.3% (compared to 26.7% in 2004).[6]
- *Number of healthcare professionals:* 11 per 10,000 population.[7]
- *UNCRPD status:* Signed the Convention and its Optional Protocol on 1 October 2007.[8]
- *Budget spent on disability:* Estimated around US$8 million government support (likely through international sources) and US$7 million NGO support.[9]
- *Measures of poverty and development:* Despite constant economic growth since 2004, many people in Cambodia remained poor, particularly in rural areas. More than 50% of Cambodia's population is younger than 21 and there is a lack of educated human resources. It was estimated that 35% of the population lived below the poverty line.[10]

VA country summary

Total mine/ERW casualties since 1979: 63,402			
Year	Total	Killed	Injured
2004	898	171	727
2005	875	168	707
2006	450	61	389
2007	352	65	287
2008	269	47	222
Grand total	**2,844**	**512**	**2,332**

- *Estimated number of mine/ERW survivors:* At least 43,926.[11]
- *VA coordinating body/focal point:* The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) coordinates VA with the support from the Disability Action Council (DAC); both lack capacity and need external technical advice.
- *VA plan:* The National Plan of Action for Persons with Disabilities, including Landmine/ERW Survivors 2009-2011; implementation slowly started in mid-2009.
- *VA profile:* Between 2005 and 2009, Cambodia remained very dependent on external support to implement services for its significant number of mine/ERW survivors and, indeed, the population in general. Cambodia was devastated by decades of war and continued to suffer from poor infrastructure, bad road networks and a shortage of well-educated staff. Relevant ministries lacked capacity to carry out or coordinate VA/disability services and a 2007 Austcare evaluation found that the government needed to be more responsive to community needs without bias or political corruption.[12] Corruption is rife in Cambodia. Services to survivors were often seen as part of community development projects, as many survivors and affected communities still lacked access to clean water, electricity, sufficient food and arable land. Healthcare varied from community to community but complex care could only be carried out in national-level hospitals in major cities. Road conditions and the cost of services were obstacles, as were the lack of well-trained staff, emergency response mechanisms and equipment or supplies. The physical rehabilitation sector functioned well, but was extremely dependent on international financial and technical support. Nationalization of the sector started but was progressing slowly. A community-based rehabilitation (CBR) network coordinated by MoSVY was started in 2006 to fill the many service gaps at community level. It continued to expand and build capacity in 2009. Psychosocial support was limited and mainly conducted by NGOs who were also crucial in the establishment and support of self-help groups. These groups served an economic reintegration, peer support,



and awareness raising purpose to assist persons with disabilities in organizing and improving their community participation. Economic reintegration activities were mainly carried out by NGOs but some government initiatives of varying quality also existed. However, it was estimated that some 400,000 children with disabilities did not have access to school and that vocational training often did not meet the needs of persons with disabilities and was frequently not followed by actual employment. Discriminatory employment policies continued to exist. Disability legislation pending since 2000 was finally approved in July 2009. Disabled people's organizations (DPO) in Cambodia are active and increasingly well-organized but still need capacity reinforcement. In the short to medium term, no end to NGO and international support for VA/disability could be envisioned. However, donor interest and support has decreased slowly but steadily since 2005.[13]

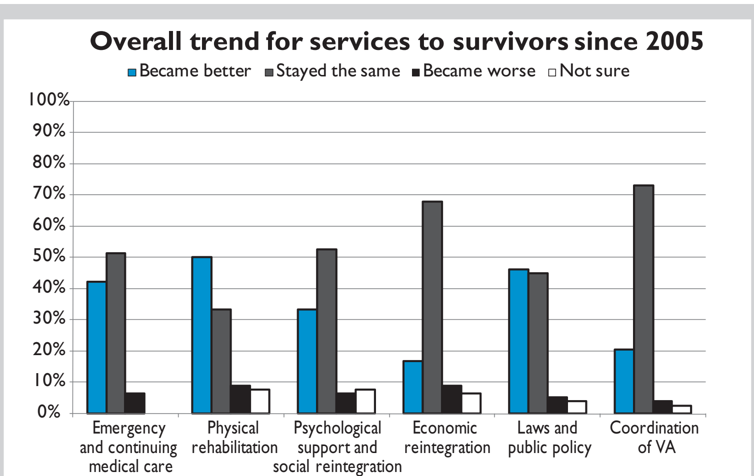
VA progress on the ground

Respondent profile[14]

By July 2009, 78 survivors between 20 and 59 years old responded to a questionnaire on progress in VA in Cambodia since 2005: 67 men and 11 women. Some 71% were heads of households and 77% owned property. Nearly three-quarters of survivors (74%) lived in villages with limited services; 18% lived in remote areas without services; and 5% lived in a main city with a variety of services or the capital.[15] Respondents came from Battambang, Siem Reap, Pursat, Kampong Thom, Kampong Speu, Banteay Meanchey, and Oddar Meanchey provinces. Some 36% of respondents had not received any formal education and just 18% had gone to secondary school or higher. Just one person reported being unemployed prior to the incident; this increased to five after the incident. Most survivors changed their jobs as a result of the incident and became farmers (55 or 71%). Many respondents had their incident during the conflict (1979-1991) when they were recruited to fight or shortly after. Just 8% of people said that their income was sufficient. This profile corresponds with casualty data, which indicates that mines/ERW continue to cause casualties in all parts of Cambodia, usually young males. While the vast majority of casualties are civilians killed or injured in rural areas, many of the older casualties would have been civilians forced to fight during the conflict. Most casualties were recorded in Battambang and Banteay Meanchey provinces.

General findings

Overall, a significant number of survivors saw improvement in VA/disability service provision since 2005, but a significant percentage also found that the situation remained unchanged. Most progress was noted in physical rehabilitation and least in economic reintegration. Some 60% of respondents found that they received more services in 2009 compared to 2005, and 67% found that the services had improved. It needs to be noted that, in addition to the services asked about, many survivors had much more basic needs, such as food aid, clean water and housing. Jesuit Services Cambodia already noted in 1999 that many survivors lacked the most basic necessities; they confirmed this was still the case in 2004, and now in 2009, for a significant number of survivors the situation remained the same.[16] Due to their often low educational levels, many respondents found many questions difficult to answer. Practitioners generally saw more improvement than survivors, particularly in psychosocial support and economic reintegration.



The largest group of respondents (41%) had not been surveyed by NGOs or the government in the last five years, but the second largest (22%) group had been surveyed more than four times. Some 45% of respondents felt that survey activity resulted in their receiving more information about services, as well as more actual services. But just 18% felt it was easier to obtain a pension. Some 21% of survivors had had the opportunity to explain their needs to government representatives at least once. Cambodia operates a very efficient data collection mechanism (the Cambodia Mine/UXO Victim Information System, CMVIS) which captures nearly all casualties in Cambodia, so all respondents would have been interviewed by a CMVIS data collector at one point. CMVIS also started conducting a survey of assistance received by survivors in 2006, but the project remained suspended as of August 2009 due to problems with the questionnaires and a lack of support from its international advisor. The collection of this type of data was seen as crucial to better VA planning and was one of Cambodia's goals for 2005-2009. Since 2007, CMVIS also noted that due to the decreasing number of casualties, it had to reduce its staff which affected its capacity to maintain links with communities and provide referral and information.

Two-thirds of people thought that services for female survivors were equal to those available to male survivors, but 15% said that services for women were "much worse". Women responded more negatively: 45% said services were "equal" and 27% said "much worse". Some 30% of respondents were not sure whether services for children were adapted to their age and 26% thought this was "sometimes" the case.

Emergency and continuing medical care

More than half of survivors (51%) thought that, overall, healthcare had remained the same since 2005 and 42% saw improvement. Some 41% thought that survivors "sometimes" received the medical care they needed; 21% said they "mostly" received needed services; but 14% said this was "almost never" the case. The area of most progress was increased affordability of medical care (68% saw progress), followed by improved infrastructure (67%), and an increased number of health centers (62%). The areas of least progress according to survivors were: medical teams with more complete skills (17% saw improvement) and the availability of emergency transport and of better equipment or supplies in health centers (18% each). Some 53% of survivors thought that the government had increased its support to the health sector. Among practitioners, 47% thought that healthcare had remained the same since 2005. The areas of most and least progress were the same as those identified by survivors. The largest group of practitioners (on average 60%) thought that the government had maintained its efforts.

Basic health services are available at community health centers but for more complex assistance survivors need to go to district referral hospitals or to national-level hospitals. While health centers have been constructed and infrastructure, including road networks have been improved as part of broader development projects, many hospitals still lacked supplies, equipment and even water or electricity. Medical care, medication and accommodation are usually not free of charge, and the cost of continuing medical care in particular was prohibitive for most survivors. However, NGOs assisted in covering the medical costs, transport and food. Cost-sharing and health equity funds also existed to increase access to services for poor people, although mine/ERW survivors were not systematically granted access to these. Only the NGO hospital in Battambang gave high-

quality trauma care, and did so free of charge. Probably, most respondents had been able to benefit from the above measures for their medical cost, but for some an improved economic situation or the existence of community self-help groups (*see below*) will have contributed. Throughout 2005-2009, Cambodia acknowledged that emergency response mechanisms were inadequate, and standards for emergency response, although developed, were not well-implemented. A lack of coordination between NGOs working in mine/ERW affected areas and the government for emergency care were also noted. Medical staff and first aid training was, in 2009, still considered inadequate, despite efforts by some NGOs and the Cambodian Red Cross, possibly confirmed by the fact that survivors did not see remarkable progress in this area.[17]

Physical rehabilitation

Half of the respondents found that physical rehabilitation had improved since 2005 and 33% thought it had remained the same. The largest group of respondents (38%) believed that survivors "always" received the physical rehabilitation services they needed and 33% said that the needed assistance was "sometimes" received. Survivors saw improvements in affordability, quality and staff across the board. Areas of most progress were: more inclusion of transport and accommodation costs (85% noted improvement), better quality mobility devices (87%), increased affordability of services (91%), and increased availability of free repairs to devices (92%). But much fewer respondents (35%) found that waiting periods had become shorter. Just 23% found that they could get services closer to home and 18% thought there were more rehabilitation services. Some 80% of practitioners saw improvement in physical rehabilitation, and, overall they thought that the government had maintained its efforts.

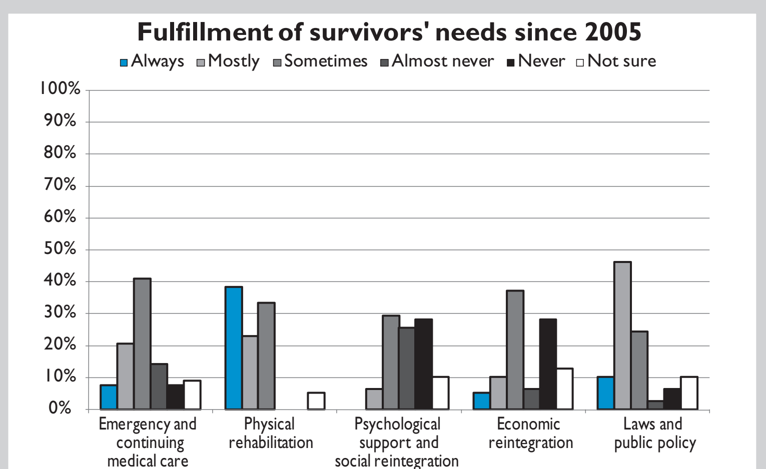
Throughout 2005-2009, it was reported that Cambodia's rehabilitation sector was well-organized, of sufficient quality and could deal with the existing needs. However, since the early 1990s, the sector has been almost completely dependent on international organizations. Throughout 2005-2009, these international organizations financed the cost of treatment, materials and salaries, and have ensured training and quality improvements. They also covered the cost of accommodation and transport or made transport agreements with local authorities.[18] Access to services remained problematic if transport costs were only reimbursed to patients afterwards. Already prior to 2005, international organizations urged the government to take on more responsibility for physical rehabilitation.[19] The government remained reluctant until, in mid-2008, a memorandum of understanding was signed between MoSVY and the five rehabilitation providers in which the ministry committed to gradually take over all financial responsibility for the management of physical rehabilitation services by 2011. A review of responsibilities, completed in 2008 under the hand-over process, showed that MoSVY had achieved less than half of its responsibilities.[20] The service providers noted that MoSVY was late with its contribution to the centers' running costs and that they might lose staff, as government salaries were considerably lower than those paid by operators and staff might not fit the civil servant criteria.[21] The ICRC had already handed over management (but not the entire financial burden) of its centers over to MoSVY and foresaw fewer problems, even though it also paid incentives.

In 2004, the number of rehabilitation centers decreased from 14 to 11, due to a lack of funding.[22] This explains why survivors did not see improvement in obtaining services closer to home. Since 2006, CBR activities funded by UNICEF have started. Although outreach services covered some 20 provinces, Cambodia acknowledged that further improvements should be made in outreach and referral, particularly from hospitals.[23] Service providers thought that the number of centers might decline further after 2011, again due to decreasing donor commitments and because MoSVY would not have the financial capacity to manage the centers by that time. For example, MoSVY allocated US$100,000 to physical rehabilitation in 2007 (through international funding), but the actual annual cost was estimated at more than US$4 million.[24]

Psychological support and social reintegration

More than half of survivors (53%) thought that, overall, psychological support and social reintegration services had stayed the same since 2005. Some 28% thought that survivors "never" received the psychosocial support they needed and an additional 26% thought that this was "almost never" the case. Most progress was perceived in attitudes: 51% thought that survivors were considered to be "charity cases" less often; 55% thought there was less stigma around seeking counseling; and 65% felt more involved in community activities. Some 64% of survivors also felt more empowered. However, just 18% thought that there were more psychosocial support services and 19% thought that there were more peer support groups. More than half of the practitioners thought that there was an improvement in psychosocial support. Most notably, 67% found there were more services.

Indeed, through the CBR network, many self-help groups for persons with disabilities have been started with the support of NGOs. However, while these groups could serve a peer support purpose, their main purposes were economic support and awareness raising. While open to all persons with disabilities, some survivors said they were too poor to participate in the groups. It is also possible that the expansion of the CBR network and self-help groups had not reached respondents yet or that the development of activities was too recent for survivors to see an impact. The awareness-raising component of the CBR network might have played a role in improved community attitudes and involvement. Most practitioner respondents belonged to organizations supporting self-help groups, which would have influenced their response. However, it was also noted that NGOs did not coordinate their self-help group activities or exchange lessons learned. Cambodia acknowledged, in 2009, that there was no formal mechanism or policy for psychological care and that just one facility provided basic training. Mental health units of government hospitals provided some assistance but did not function well and it was noted that MoSVY and the Ministry of Health needed more resources and capacity to work on the issue.[25]



Economic reintegration

The majority of survivors (68%) thought that, overall, economic reintegration opportunities had remained the same since 2005 and 17% saw improvement. Some 37% believed that survivors "sometimes" received the economic reintegration they needed and 28% said this was "never" the case. Nearly three-quarters of respondents thought that unemployment was so high that survivors were the last to be chosen for a job. However, 73% also thought that educational and professional discrimination had decreased and some 63% thought there were more economic opportunities (micro-credits or small business schemes) in their areas. However, just 37% thought that there were more employment opportunities and 31% saw more job placement opportunities. The area of least satisfaction was pensions, where only 28% saw an improvement. A majority of practitioners (60%) found that there were more economic reintegration activities in 2005 than in 2009. The areas of most progress for some 73% of practitioners were: decreased educational and professional discrimination and increased access to vocational training and education.

Inclusive education programs for children with disabilities have been developed by the government and disability awareness training was given to teachers throughout 2005-2009. Education became compulsory for all children in 2007. Government vocational training centers also existed but needed strengthening. Low disability awareness among local

authorities prevented them from encouraging persons with disabilities to go to school, and few children with disabilities actually accessed education. Survivors could often not afford education for their children. Vocational training and economic reintegration for survivors are carried out mostly by NGOs, but the success rate of job placements is low.[26] Cambodia also noted for 2008 that, "many [economic reintegration] projects have been postponed or ended due to the lack of funding."[27] In 2009, the draft VA status report to be presented at the Second Review Conference also showed that the number of people accessing vocational training gradually decreased between 2005 and 2008.[28]

However, the survivors' (and practitioners') perceptions of increased economic opportunities are also related to the expansion of the self-help groups, which provided revolving loan schemes or shared the costs for small-scale projects. The generally low education level of survivors hampered their job placement perspectives. Although job placement services existed, only a fraction of persons with disabilities registered was actually placed.[29] Discriminatory hiring policies continued to exist for government schools (although the Ministry of Education was revising its policies). It was even reported that MoSVY continued to stipulate in its hiring requirements that candidates should be "able-bodied."[30] It is not surprising that survivors saw pensions as an area of least improvement, as these were only for soldiers injured during the conflict. But pension budgets were also reduced because it was thought that many people receiving pensions no longer fit the criteria. Other problems with pensions were delayed payments, bribery and the selling of entitlements in times of need.[31]

Laws and public policy

The largest group of respondents (46%) thought that the rights of survivors had been protected more since 2005 and the same percentage thought that the rights of survivors were "mostly" respected. Most survivors (70%) saw progress in the development of policies and legislation relevant to survivors and 45% also thought that legislation was enforced better. Some 71% of survivors found that awareness about the rights of persons with disabilities had increased and 68% thought that negative terms about persons with disabilities were used less often. More than half of the practitioners (53%) also saw improvement in the laws and public policies for survivors. According to them, most progress was made in the development of legislation (67% thought so) and in decreasing discrimination (80%).

It is likely that these results are strongly linked to the progress made in approving disability legislation. The Law for the Protection and Promotion of the Rights of People with Disabilities was first drafted in 2000, re-drafted in 2004 and submitted to the government in 2006.[32] But real advances only started to be made in 2008-2009 when the king of Cambodia finally signed the law on 8 July 2009. For DPOs and NGOs, this legislation is key to improved VA and disability implementation, even though some acknowledged that certain amendments are needed to bring the legislation in line with the UNCRPD. The awareness-raising efforts and lobbying of DPOs, NGOs and the CBR network have played a crucial role in the adoption of legislation, and exposing discrimination.

MoSVY representatives were not able to respond to preliminary findings and DAC noted that it did not have the capacity or the mandate to provide a response. The Ministry of Health noted that its responsibilities were limited to emergency and continuing medical care and psychosocial support, which it hoped to implement successfully to 2011. One advisor noted that, although progress is slow, there have been several steps in the recognition of the rights and needs of survivors. The person added that there may be survivors that have not seen benefits on an individual basis but the sector as a whole has experienced improvements.

VA process achievements

Year	Form J with VA	ISC VA statement	MSP VA statement	VA expert	Survivor on delegation
2005	YES	YES	YES	YES	NO
2006	YES	NO	YES	YES	NO
2007	YES	YES	YES	YES	NO
2008	YES	YES	YES	YES	NO
2009	YES	YES	N/A	YES	NO

Note: Cambodia was one of the co-chairs of the Standing Committee on Victim Assistance and Socio-Economic Reintegration in 2007-2008.

In 2005, Cambodia acknowledged that, it "has not done enough for [mine/ERW survivors]. Donors too have not been insistent enough that some of their funds must go directly to assisting the victims." It added, "We have not been creative, compassionate and clever enough to address the real needs of some of the poorest in our country…"[33] In 2009, Cambodia described its situation in much the same way as in the 2005 Zagreb Progress Report, particularly for psychosocial and economic reintegration.[34] Nevertheless, improvements to the lives of mine/ERW survivors and persons with disabilities have been made. But many of these achievements were realized by NGOs with extensive international support and less so by the government, which lacked the capacity and financial means throughout 2005-2009. Despite increased involvement, disability was not a high government priority. Survivor responses indicated a similar sentiment: 65% thought that the government was more involved, but 81% noted that the government lacked resources and 62% said the government also lacked the political will.

As part of its commitment to the implementation of the 2005-2009 Nairobi Action Plan, Cambodia developed some objectives in 2005. The majority of these objectives related to the development of plans and guidelines, as well as data gathering to facilitate the making of these plans, most notably a VA action plan to be started in 2006. Prior to that, in 2004, the Cambodian Mine Action and Victim Assistance Authority's (CMAA) decided to "develop a national plan on the needs of mine/ERW survivors in cooperation with the Disability Action Council (DAC)."[35] A strategic plan 2004-2009 was developed and discussed.[36] Throughout 2005-2009, this plan was not implemented because no budget was allocated to it,[37] nor was it used as the basis for developing other plans because it was unavailable during discussions.

In February 2009, the National Plan of Action for Persons with Disabilities, including Landmine/ERW Survivors 2009-2011, was finalized. Some discussions started in 2006, but the drafting process, which took nearly two years, was only kick-started once external technical support was provided to nudge DAC into action. Broad consultations were held, but some NGO representatives noted that there was a lack of continuity in those participating in the meetings from both the government and civil society side, and that the ministries often did not send people with decision-taking mandates. Nevertheless, practitioners saw improved coordination and 21% of survivors also found this to be the case. Some 36% of survivors knew who was in charge of VA/disability coordination; 42% thought that their needs were taken into account when setting VA priorities and 45% thought that survivors were included in coordination and planning.

Most of the 2009-2011 VA/disability plan's objectives had timelines for 2011 and the plan focused almost entirely on capacity building, information collection/dissemination, enhancing coordination and fundraising. It appears to be assumed that the current service providers will continue their activities, which led non-governmental stakeholders to say that the plan was not conducive to real action and contained objectives that were too broad, unclear and in some cases unrealistic, because it placed so much responsibility on MoSVY. It was said that a roadmap detailing actual activity implementation was needed and that the implementation of the plan would probably be limited to what was realistically feasible under the current capacity and budget constraints. As the 2009-2011 VA/disability

plan was only finalized in early 2009, some operators had not yet received the final plan. However, because many were consulted in the development of the plan and no real change in their activities was envisioned, they thought their activities were in line with the plan.[38]

Responsibility for the coordination of the plan was assigned to MoSVY and one of the main aims of the plan was to strengthen the ministry's capacity and its relationships with implementing partners and survivors and other persons with disabilities.[39] The roles of DAC and CMAA are unclear. Already in 2002, CMAA delegated coordination of VA to MoSVY with the technical support of DAC. None of the three bodies had the financial means and capacity to coordinate or monitor VA in 2005-2009. It was said that the government capacity in conducting VA/disability activities was "in its infancy."

The success rate of the VA/disability plan for 2009-2011 was largely dependent on the capacity of MoSVY to take on a leadership role. Cambodia said that the lack of "a comprehensive strategic management agenda for MoSVY… has made both the proper coordination and accountability of government services very difficult." But added the Nairobi Action Plan gave "an opportunity to take the first steps in articulating specific, measurable, and realistic objectives that would be relevant to the disability sector as a whole."[40] Indeed, MoSVY's initial mandate was limited to war veterans and its structure at all levels was insufficient to deal with the broader disability mandate. Its branches are "often under-resourced, inexperienced, or reluctant to implement MoSVY directives."[41] A disability advisor started assisting MoSVY on 1 July 2009 – until 2006, this person was the director of DAC trying to make DAC a more efficient and independent body.

The DAC and its various working groups provide technical advice to MoSVY, but many of these working groups do not function without external technical support. The viability and sustainability of DAC, which depended on external funding was questioned, unless national contributions would increase. Some also noted that while DAC was supposed to be a semi-autonomous body, it was controlled by MoSVY. CMAA focused on its other mine action activities and its role for VA was limited to reporting and monitoring, a task it said it could not do because the necessary data was not provided by DAC and MoSYV.[42]

In April 2009, the process of transforming the Steering Committee for Landmine Victim Assistance co-chaired by MoSVY and CMAA into the National Disability Coordination Committee (NDCC) was started (also chaired by CMAA and MoSVY). The NDCC's work would be expanded from coordinating VA plans to a general coordination role for the disability sector. Throughout 2005-2009, MoSVY has favored a mainstreaming approach to VA. This approach resulted in the 2009-2011 plan encompassing the needs of all persons with disabilities.

Already in 2004, the Cambodian Campaign to Ban Landmines said that the challenge for the Cambodian government was to address the rights and needs of survivors and their affected communities through decentralized structures and the provision of realistic budgets to meet the needs. They added that international assistance was essential to provide the resources needed for sustainable activities.[43] In 2009, both government and civil society agreed that NGOs and DPOs still carried out and financed most services. Many thought that this would remain unchanged and that even in 2011 MoSVY would not have the financial capacity to conduct VA/disability activities. The VA/disability plan was also seen as a major tool for fundraising. But funding might not be forthcoming, as several operators mentioned donor fatigue and increased funding challenges. These challenges would also make it difficult to maintain the same level of operations in Cambodia in the medium to longer term.[44]

Conclusions

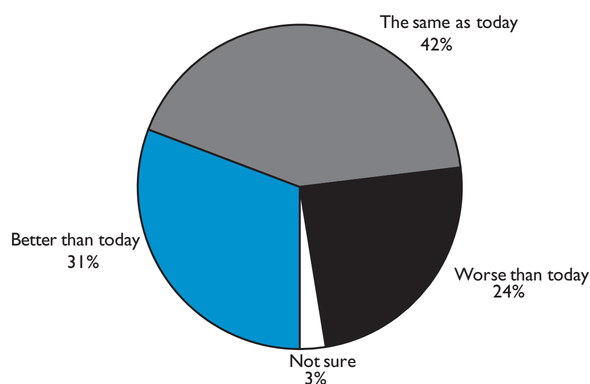
- The vast majority of services for survivors and persons with disabilities were carried out by NGOs and DPOs, and paid for with extensive international resources.
- Most improvement was seen in medical care and physical rehabilitation, especially because costs for survivors appeared to be better covered.
- The CBR network and self-help groups resulted in higher disability awareness and increased economic opportunities but had less of a peer support role.
- Economic reintegration and particularly employment opportunities remained insufficient.
- Advances in legislation concluding in the adoption of disability legislation after more than eights years were seen as major improvements.
- Government involvement and interest in disability issues increased, but this did not result in increased service implementation by the government.
- Capacity and funding challenges at government level were considered to be serious obstacles in 2005-2009 and it was envisioned that these challenges would continue to persist well into 2010-2014.
- The 2009-2011 VA/disability plan focused on government-level improvements but less on actual service provision.
- Donor fatigue and prospects of reduced aid were considered as challenges to continuing the current level of service provision.

Suggestions for the way forward

When asked about how they saw their situation in five years: 42% of survivors thought it would stay the same; 31% thought it would get better; and 24% thought it would be worse. To assist in a building a better future, the following suggestions may be taken into account:

- Urgently implement the 2009-2011 VA/disability plan and adjust the plan as needed to reflect more precisely what service provision will be implemented and by whom.
- Realistically assess the capacity and financial means of MoSVY to implement the plan and readjust responsibilities accordingly, especially in light of possible NGO departures in the medium term.
- Ensure continuity and sufficient mandate for the disability advisor position at MoSVY and, in the medium term, ensure that this position becomes integrated in the ministry's hierarchy.
- Increase DAC autonomy and urgently increase its capacity to serve its role as policy-maker, technical advisor and monitoring mechanism for the disability sector.
- Continue to strengthen the CBR network to include more psychosocial support activities and formalize coordination and practices of self-help groups.
- Increase economic reintegration opportunities through the CBR network, but also by developing more suitable vocational training and more effective job placement mechanisms.
- Ensure that the hand-over of the physical rehabilitation sector is done in a manner that is sustainable for MoSVY and the functioning of the centers. Investigate alternatives in case financial and technical capacity at ministerial level proves inadequate.
- Start increasing national resources for VA/disability, but actively seek continued international support for the implementation of the VA/disability plan for 2009-2011.
- Continue to provide adequate international support but insist on greater transparency on the use of funding.

What do you think your situation will be like in five years?



Seng Sam and his fish pond
© Disability Development Services Pursat

In his own words: the life experience of Seng Sam

In their own words…

Respondents described themselves as: living in difficult conditions, wanting more agricultural land, uncertain of how to proceed now that they are disabled, poor, hopeful for a better future, having problems carrying out daily activities…

In their own words…

The main priority for VA for the next five years is:

- Provide food and agricultural land (many).
- Land and support to grow livestock.
- Skills training.
- Establish a group for disabled persons to make information sharing easier.
- Provide micro-credit to start a new type of job.
- Support an alternative livelihood.
- Support rehabilitation.
- Provide help in finding a job or teach new skills.
- Give access to healthcare.

In their own words…

If countries really cared about survivors they would:

- Encourage disabled people.
- Support livelihoods.
- Help finding a job.
- Provide a house.
- Give mental support and skills training.
- Provide start-up capital for a new livelihood activity.
- Continue [physical] rehabilitation.

Seng Sam, 48, lost his right leg as a soldier after stepping on a landmine in 1991. He lives with his wife and five children in Chrey Krem village (Kravanh district, Pursat province). For a long time after his incident, his family lived in extreme poverty, as he says "we had to live from hand to mouth." Seng Sam and his wife were not able to send their children to school, as they did not have land to cultivate or cattle.

However, with the help of one local NGO (Disability Development Services Pursat, DDSP), Seng Sam became a member of a self-help group in 2003. He also received counseling from NGO staff and encouragement from his family and community members. Seeing his progress, DDSP decided to give him training in community organization, as well as animal raising and vegetable growing skills. In the meantime, Seng Sam has taken a study tour to learn good practices from other communities. He managed to clear a sizeable plot of land of trees. And today he is growing crops and raises a range of animals, including fish, chickens, ducks, pigs and even a cow and buffalo.

The life of his family has improved quite significantly and now Sam Seng can afford to send his children to school. People think he is a very good community leader and role model for others. Seng Sam adds, "I am very committed to try my best for my family, but also to maintain the self-help group and the sustainability of my community after DDSP leave."