Accessibility and Inclusive Services on Explosive Ordnance (EO) Victim Assistance: **“The Case of Cambodia"**

Situational Analysis of Victim Assistance for EO victims

With support from

ARMAC asean

AKCF ASEAN-KOREA COOPERATION FUND 한 - 아세안 협력기금

Disclaimer:
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Action on Disability and Development Cambodia (ADD)
Battambang Disabled People's Organisation (BDPO)
Cambodian Mine Action Centre (CMAC)
Cambodia Red Cross (CRC)
Cambodian Self-Help Demining (CSHD)
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Disability Development Services Program (DDSP)
EXCEEED Worldwide
The HALO Trust
The Handa Foundation
Humanity and Inclusion (HI)
International Committee of the Red Cross (ICRC)
Jesuit Refugee Services
Mines Advisory Group (MAG)
Persons with Disabilities Foundation (PwDF)
Ministry of Health (MoH)
Ministry of Social Affairs, Veterans Affairs and Youth Rehabilitation (MoSVY)
United Nations Development Programme (UNDP)
United States Humanitarian Demining Research and Development Program

Photo Credit

Front Cover Photo: A man with an amputated leg sits on his farm explaining the practicalities of using a prosthesis while farming to researcher George Fairhurst - November 2021

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Acronyms

ACCESS	Australia-Cambodia Cooperation for Equitable Sustainable Services
AMS	ASEAN Member States
APMBC	Convention on the Prohibition of Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction (Anti-Personnel Mine Ban Convention / Mine Ban Treaty)
ASEAN	Association of Southeast Asian Nations
CCW	Convention on Prohibitions or Restrictions on the Use of Certain Conventional Weapons Which May be Deemed to be Excessively Injurious or to Have Indiscriminate Effects (Convention on Certain Conventional Weapons)
CCM	Convention on Cluster Munitions
CDPO	Cambodian Disabled Peoples Organisation
CMAC	Cambodian Mine Action Centre
CMAA	Cambodian Mine Action and Victim Assistance Authority
CMAS	Cambodian Mine Action Standards
CMVIS	Cambodia Mine/ERW Victim Information System
COMAC	Conflict Mitigation Assistance for Civilians
CRC	Cambodian Red Cross
CRPD	Convention on the Rights of Persons with Disabilities
CSHD	Cambodian Self-Help Deminers
DAC	Disability Action Council
DAWG	Disability Action Working Group
DFAT	Australian Government Department of Foreign Affairs and Trade
DPO	Disabled People's Organisation
DRA	Disability Rights Administration
DWDP	Department of Welfare for Persons with Disabilities
ERW	Explosive Remnant of War
EO	Explosive Ordnance
EORE	Explosive Ordnance Risk Education
ESP	Education Strategic Plan
GDP	Gross Domestic Product
GICHD	Geneva International Centre for Humanitarian Demining
GNI	Gross National Income
HEF	Health Equity Fund
HMA	Humanitarian Mine Action
HSP	Health Strategic Plan
ICRC	International Committee of the Red Cross
IED	Improvised Explosive Device
IDP	Internally Displaced Person
IDPoor	Identification of Poor Households Program
IMAS	International Mine Action Standards

IMSMA	Information Management System for Mine Action
INGO	International Non-Governmental Organisation
IP	Implementing Partner
MAG	Mines Advisory Group
MoEF	Ministry of Economy and Finance
MEYS	Ministry of Education, Youth and Sport
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MoI	Ministry of Interior
MoInf	Ministry of Information
MoLVT	Ministry of Labour and Vocational Training
MoP	Ministry of Planning
MoSVY	Ministry of Social Affairs, Veterans Affairs and Youth Rehabilitation
MoWA	Ministry of Women's Affairs
MRE	Mine Risk Education
NDSP	National Disability Strategic Plan
NMAA	National Mine Action Authority
NMAS	National Mine Action Strategy
NSPPF	National Social Policy Protection Framework
NGO	Non-Governmental Organisation
OPD	Organisation of Persons with Disabilities
PO	Prosthetist Orthotists
POT	Prosthetist Orthotists Technician
PRC	Physical Rehabilitation Centre
PwDF	Persons with Disabilities Foundation
QLS	Quality of Life Survey
RGC	The Royal Government of Cambodia
SBCF	The Sir Bobby Charlton Foundation
SPPF	Social Protection Policy Framework
TRG	Technical Reference Group
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNMAS	United Nations Mine Action Service
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNTAC	United Nations Transitional Authority in Cambodia
USAID	United States Agency for International Development
UXO	Unexploded Ordnance
VA	Victim Assistance
VIC	Veterans International Cambodia
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

Foreword

In building a peaceful, secure, and stable region, the Association of Southeast Asian Nations (ASEAN) adopts a comprehensive approach to security which enhances its capacity to deal with existing and emerging challenges under the ASEAN Political Security Blueprint 2025. Among the key elements of the peaceful, secure, and stable region is the promotion of the ASEAN Member States' active participation in peacekeeping and post-conflict peace building efforts, in accordance with the capacity of respective ASEAN Member States and the promotion of the ASEAN Regional Mine Action Center (ARMAC) to study, document, and share best practices to address humanitarian aspects of landmines and explosive remnants of war.

ARMAC is a centre of excellence established in 2012 under the ASEAN Political Security pillar to encourage the efforts to address landmines and explosive remnants of war (ERW) for interested ASEAN Member States (AMS). Inaugurated on 25 May 2016, ARMAC aims to collectively tackle the humanitarian aspects of landmines and ERW through an integrated approach of experiences sharing, skills training and other capacity building activities. To fulfil this mandate, ARMAC is working to enhance victim assistance (VA) in Member States affected by these weapons. In pursuit of ASEAN Political Security Blueprint 2025, ARMAC has instigated research project on victim assistance in mine action.

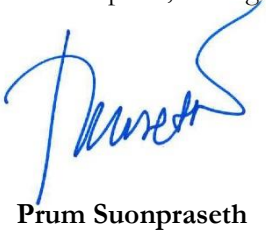
Victim assistance is the implementation of mine action-specific and broader activities to mitigate the short- and long-term impacts of landmines other explosive ordnance on individuals and communities, with considerable focus on healthcare, rehabilitation, mental health and psychosocial support, and socioeconomic inclusion. To improve victim assistance across the Southeast Asian region, ARMAC is, alongside other ventures, collecting, analysing, and disseminating information to guide and enhance the victim assistance policy and activities of government and non-government stakeholders.

As one of the most landmine-affected countries in the world, and home to one of the longest-running humanitarian mine action programmes, ARMAC deemed it appropriate to grant special attention to Cambodia in this early stage of our research effort. Due to the immense impact of landmines and UXOs on the country, Cambodia requires substantial support to effectively implement victim assistance, including increased access to valuable, reliable, and up-to-date research. Because of Cambodia's prolonged and significant humanitarian mine action effort, ARMAC believes that other affected-Member-States can learn from their victim assistance experiences and adapt and apply lessons from Cambodia to domestic policy and programmes.

This research project aims to analyse the victim assistance frameworks and implementation of associated activities in Cambodia. This report is the first output from the project on *Enhancing Victim Assistance Program in ASEAN Member States funded by ASEAN-Korea Cooperation Fund*, and analyses the victim assistance framework in Cambodia, and considers the roles and responsibilities of mine action-specific and broader stakeholders in the country.

ARMAC gratefully acknowledges the funding for this research from the Government of the Republic of Korea provided under the ASEAN-Korea Cooperation Fund.

It is our hope at ARMAC that the discussion in this report will serve as a tool to enhance the policies and programming to address the short- and long-term impacts of explosive ordnance on individuals and communities the ASEAN region, especially in Cambodia. It is also our hope that the report's findings signal to the international community that half of ASEAN still requires significant support to address the effects of landmine/ERW. ASEAN is one of the most important developing regions in the world but, without addressing these impacts, the region will continue to face significant barriers to growth and prosperity.



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Contents

1. Introduction

In 2012, the ASEAN Regional Mine Action Center (ARMAC) was established by the ten ASEAN Member States with a mandate to address the impacts of explosive ordnance (EO) - predominantly landmines and explosive remnants of war (ERW) - on communities and individuals in countries within the ASEAN community, and to facilitate cooperation among the member States to achieve this objective.

In 2021, empowered by the ASEAN-Korean Cooperation fund, the ASEAN Member States (AMS), in collaboration with ARMAC, activated an initiative to enhance Victim Assistance (VA) in ASEAN Member State countries that have reported casualties from EO (Cambodia, Laos Myanmar, Philippines, Thailand, and Vietnam, and the Philippines). The specific objectives of this initiative are:

1. to promote the establishment of the VA network as a regional platform for various stakeholders among ASEAN;
2. to assist the AMS on victim-assistance-related knowledge sharing, need/s and resource/s assessment and possibility of its mobilisation;
3. to assess the needs of victims of EO in affected AMS for further assistance;
4. to assist the AMS in providing psychosocial support to victims of EO;
5. to conduct research on 'Community Perspectives of Humanitarian Mine Action in Lao PDR and Vietnam', and 'Inclusive Services for EO Victims: The Case of Cambodia'.

Aligning with these objectives, the underlying goal of this report is to mitigate the short- medium- and long-term impacts of EO[1] on communities in Cambodia by fulfilling objective five in the list above. Accordingly, the aim of this report is to provide a current and comprehensive understanding of VA frameworks[2] in Cambodia, assessing the implication on the accessibility and inclusiveness of services for EO victims. To this end, the report will first summarise the historical context of EO harm in Cambodia, then establish the responsibilities of the Royal Government of Cambodia (RGC) to provide VA under their international obligations, and then analyse the frameworks of VA in Cambodia, providing insight on the implications of Cambodia's frameworks on the inclusivity of services for EO victims.

It is the hope of ARMAC that this report can be used as a tool by both government and non-government operators in Cambodia to identify areas of VA frameworks that require revision or reinforcement to enhance the inclusivity of services for victims of EO and, by association, persons with disabilities.

[1] EO is used as a catch-all term in this report to refer to landmines and ERW (UXO and AXO) in Cambodia. See Appendix 1 for more detail on the key terms and definitions used in this report. When referencing or quoting official policies, laws, and other documents, the terminology used by those documents will be used in place of the standardised terms and definitions used in this report.

[2] The term 'frameworks' is used in this report as a generic term to refer to national and subnational policies, laws, strategies, standards, regulations, and other official documents relating to the Royal Government of Cambodia's description, management, and organisation of public structures and services.

2. Methodology

2.1. Objectives

This report aims to mitigate the short- medium- and long-term impacts of EO on communities in Cambodia by indicating to humanitarian mine action (HMA) and broader (relevant) stakeholders the aspects of national frameworks in Cambodia require revision or reinforcement to realise Cambodia's VA obligations under relevant international conventions.

The primary focus within this objective is to analyse how inclusive relevant services in Cambodia are of EO victims and persons with disabilities[3]. Framing this as research questions, the report aims to answer the following: 'what are inclusive VA services?', and 'based on inferences from national and subnational frameworks, how inclusive are VA services in Cambodia?'.

Although VA is a broad term relating to a breadth of services, the report focuses on medical care, physical rehabilitation, socioeconomic inclusion, and mental health and psychosocial support.

To achieve the report's objectives, it will:

build a contextual understanding of the impact of EO on Cambodia;

identify relevant obligations and responsibilities of Cambodia to support victims under international conventions and laws;

conduct a situational analysis of the frameworks relevant to the VA system in Cambodia, and provide insight on how they influence the inclusivity of VA services; and

present a discussion based on the analysis on potential ways to enhance the inclusivity of VA in Cambodia, indicating areas of Cambodia's frameworks that require revision or reinforcement.

2.2. Definitions and Guiding Principles

The subject of this study, VA, relates to mechanisms to protect and support victims (direct (survivors of EO harm) and indirect)[4] of EO, including medical care, mental health and psychosocial support (MHPSS), physical rehabilitation, and socioeconomic inclusion[5].

[3] Persons with disability are included in the focus of this study because of the two groups' overlap regarding their needs and the type of services and support that they require.
[4] There has been debate around the use of the term 'victim' to describe someone who has survived an incident of EO harm, but, for the purpose of clarity and complicity, following the guidance of IMAS 13.10., this report uses 'victim' as a term to describe persons directly and indirectly affected by EO contamination or explosion.
[5] See Appendix I for a full, detailed, list of definitions and their sources.

For the purpose of this study, the term 'frameworks' is used as a generic term to refer to national and subnational policies, laws, strategies, standards, regulations, and other official documents relating to the Royal Government of Cambodia's description, management, and organisation of public structures and services. The term 'system' is used to describe these frameworks as a group, as well as all implementation mechanisms, resource capacity, and other aspects of VA in Cambodia.

The 'inclusivity' of VA services refers to the equal and indiscriminate availability and accessibility (physically and financially) of relevant services and resources to those affected by EO and persons with disabilities in Cambodia.

Within the analysis of the inclusivity of services, the situational analysis considers the following three qualities that indicate successful design of inclusive VA services:

Suitable – To what extent VA policies and programmes are appropriate in consideration of the needs of those affected by EO.

Effective – To what extent VA policies and programmes achieve the objectives of victim assistance, in line with the relevant international conventions, action plans, and standards.

Sustainable – To what extent the policies and programmes can be sustained long-term.

As a rights-based report, the responsibilities, standards, and best practices that the report uses to guide its analysis are taken from the international laws and conventions that the RGC has ratified or acceded. The report pays particular attention of the 'Convention on the Prohibition of Use, Stockpiling, Production, and Transfer of Anti-Personnel Mines and on Their Destruction'[6] (APMBC), and the Convention on the Rights of Persons with Disabilities (CRPD), with close consideration of standards and action plans attached to these conventions.

Using international laws and standards that clearly outline the legal responsibilities and standards of stakeholders in Cambodia to address, protect, and promote the rights of EO victims through HMA-specific and broad VA mechanisms as point of reference achieves two things: first, the RGC, by agreeing to the terms of the conventions that they have signed or acceded, in theory, likely means that they recognise that the commitments are relevant to the context of Cambodia, reducing the risk of this report imposing unsuitable standards or practices on Cambodia. Second, building the analysis on a (rights-focused) legal foundation increases the potency of the report's commentary.

2.3. Research Method

This paper uses a mixed-method research approach and utilises both primary and secondary data collection.

[6] More commonly referred to as the 'Anti-Personnel Mine Ban Convention (APMBC)', the 'Mine Ban Treaty', the 'Ottawa Treaty', or the 'Ottawa Convention'. This paper uses these terms interchangeably.

Primary qualitative data was collected from semi-structured online interviews[7] with 28 leading VA stakeholders that were selected using purposive sampling (e.g. service providers, policy makers, donors) between 23rd January 2022 and 09th June 2023: 16 senior representatives from 12 non-government organisations, 10 senior representatives from six government departments/ministries, and two representatives from one intergovernmental organisation participated. Some of the stakeholders were interviewed multiple times over the specified period. All interview participants were leaders in their respective ministries or organisations at the national level, with many having direct influence or responsibility over the frameworks being analysed. The responses in these interviews were analysed qualitatively and quantitatively[8] to inform the Situational Analysis[9].

Secondary qualitative data was collected to inform a document analysis of over 200 reports, articles, and grey literature on: international laws, conventions, and standards; national law, policy, and strategy; and activity reports and implementation assessments relevant to victim assistance, humanitarian aid, development, disability, healthcare, education, rehabilitation, EO impact, education, and other related topics.[10]

Secondary quantitative data was collected from the documents described above, as well as datasets provided by stakeholders in Cambodia, and public data banks published online by various UN agencies (e.g. Office for the Coordination of Humanitarian Affairs (UNOCHA), the World Health Organisation (WHO), the United Nations Development Programme (UNDP)), the World Bank, and the Institute for Health Metrics and Evaluation, and other relevant and reliable sources. Simple descriptive analysis of the various data was used to cross-reference findings from the document analysis and the semi-structured interviews and add more context to the findings from the qualitative analyses.

2.4. Considerations

A significant gap in this research is the exclusion of interviews with a broader range of VA stakeholders in Cambodia, especially EO victims and persons with disabilities, and representatives from the subnational (provincial and community) level. Without proper consultation of a variety of representative populations, it is impossible to present a representative understanding of the needs of EO victims and persons with disabilities or the inclusiveness of VA services, especially at the implementation stage. This limitation is compounded by the lack of digitized quantitative data that can be used to evaluate the implementation of the VA-relevant frameworks that have been analysed.

[7] All interviews were conducted in English apart from 1, which was conducted in English with a Khmer translator.
[8] All interviewees were born in Cambodia or had worked in Cambodia for a several years in a relevant sector.
[9] The programme NVivo was used to help identify trends in the responses, but a thematic analysis was largely conducted manually by the researcher. The same is true for the document analysis.
[10] Following a background search of general literature, all possible variations of relevant terms related to the victim assistance and related sectors were inputted into the search engines 'Scopus', 'Google', and 'Google Scholar'. Once uncredible, inaccessible, and non-English-language sources were removed, the remaining sources were manually scanned and selected for analysis. Papers and documents were also supplied and suggested by the participants to the interviews (i.e. key stakeholders to VA in Cambodia). Where appropriate, a snowball bibliography technique was conducted from published documents identified through the search engines and those provided or suggested by stakeholders. The documents analysed focused on Cambodia specifically, included sections of references to Cambodia, or did not reference Cambodia but included activities relevant to the report's objectives.

Field visits to collect primary data from service users and subnational entities (such as local authorities and self-help groups) would enhance insights and recommendations on the inclusivity of VA in Cambodia, especially regarding the implementation of services, and produce more detailed, specific, and targeted recommendations to enhance the inclusivity of services. Providing more specific and targeted recommendations for implementation would be valuable to stakeholders of VA services in Cambodia and, ultimately, EO victims. It is, therefore, a recommendation of this paper that, building on this report, in-depth field research is conducted to assess the needs of EO victims at the community level and investigate the implementation of services.

Regarding the paper's scope, Cambodia has a responsibility under the APMBC Oslo Action Plan and the CRPD to ensure that procedures are in place to protect survivors and persons with disability in situations of risk (e.g. environmental disaster), but an assessment of this responsibility was not possible in the scope of this report due to time and budget constraints. There needs to be further investigation into the protection and assistance of EO victims and persons with disabilities during a high-risk event in Cambodia.

It was outside the scope of this project to fully investigate the gendered aspect of inclusive VA services. It is the recommendation of this report that there is a deeper investigation into the gendered aspect of VA, assessing whether women are considered and included in the design and implementation of VA in Cambodia.

Lastly, although combined with more contemporary grey literature, unpublished data, and the input on the current context from the interview participants, much of the secondary qualitative and quantitative data collected to inform the document analysis and the quantitative data collected from public databases predate 2022 and do not account for the impact of the COVID-19 pandemic, and other critical shifts in the context of Cambodia and the international humanitarian and development sectors.

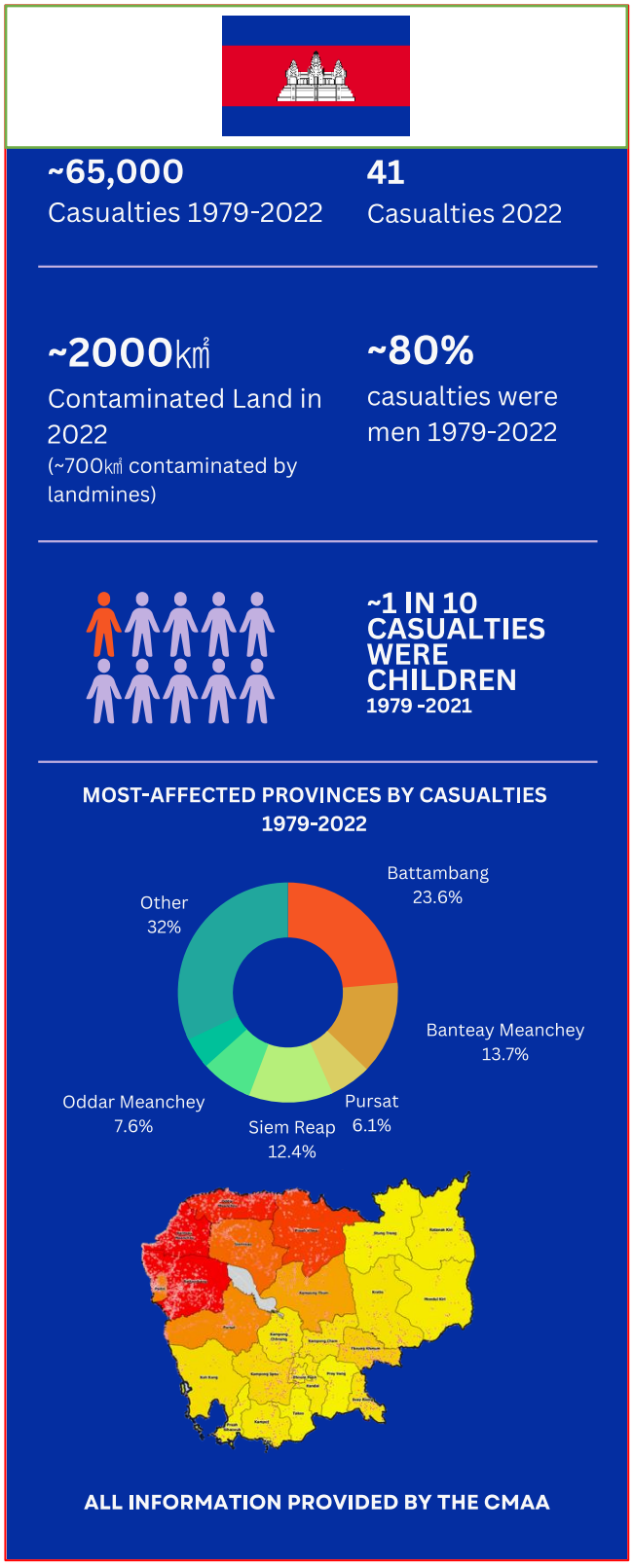
3. The Cambodian Context

A Historical Review of Contamination in Cambodia

The unparalleled level of contamination in Cambodia - and the immeasurable impact of that contamination on its civilians, society, economy, and culture – stems from decades of conflict and instability in the 20th century, almost dating back to Cambodia's independence from France in 1953.

The 1955-1975 Indochina War (also referred to as the Vietnam War), spilled over from Vietnam into Cambodia in the mid-1960s, a war in which the United States dropped approximately 6,162,000 tons of bombs and EO (Clodfelter, 1995). Cambodia was particularly hit by the bombs dropped in Operation Menu (1969-70) and Operation Freedom Deal (1970-1973). It is difficult to specify the number of bombs that landed on Cambodia during this conflict, but to cut off supply lines to the Viet Cong and the North Vietnamese troops, its estimated to be over 2.7 million tonnes – more than the amount dropped by the allies during World War II (Owen & Kiernan, 2006). Due to the imperfect design of the munitions dropped, many of these devices remain littered across Cambodia unexploded, primarily in the north-eastern region.

The civilian casualties and damage caused by these bombings created a population of traumatised and displaced people, which a Maoist political group, the Khmer Rouge, capitalised on to gain support in their fight for control of Cambodia against the US-backed government. In 1975, the Khmer Rouge captured Phnom Penh, resulting in one of the most brutal and deadly regimes of the 20th century that oversaw repression and genocide in which approximately 1.7 million people died from starvation, torture, execution, and forced labour (Lemonade & Bunleng, 2009). During this destructive period, the Khmer Rouge, led by 'Pol



Pot', laid millions of landmines[11] across the country in an attempt to prevent internal dissent and external threat.

Four long years after the arrival of the Khmer Rouge regime, the Vietnamese invaded Cambodia and captured Phnom Penh, driving the Khmer Rouge towards the Thai border, where both sides laid landmines extensively to prevent enemy movement, protect key areas, and create a sense of fear and uncertainty among enemy troops. In 1992, after 12 years of conflict between the Khmer Rouge and the Vietnamese-installed government (led by the Salvation Front) the Paris Peace Agreements were signed, signifying the end of the Cambodian Civil War and the Third Indochina War. By this time, the various fighting factions had laid millions of landmines across the country, of which many still remain in the ground, especially around the border area with Thailand.

In the year following the Paris Peace Agreements, 1992, the Cambodian Mine Action Center was established - making it one of the oldest national mine action operators in the world - to begin demining efforts in the country, supported by various non-governmental organisations (NGOs) such as Halo Trust and Mines Advisory Group (MAG). The effort to clear these mines continues today - the Landmine & Cluster Munition Monitor (2022, p.55) reported that Cambodia saw the largest area cleared of landmines in 2021 (43.73km^2).

Despite 30 years of intensive EO clearance efforts, Cambodia is still one of the most contaminated countries in the world, with approximately 2,000km^2 of contaminated land, 716km^2 of which is contaminated by landmines (Landmine & Cluster Munition Monitor, 2022, p. 27). In line with the history of conflict outlined above, Cambodia's contamination is not consistent throughout the country, with the northwest region and the border of Thailand heavily afflicted by landmines, and the northeast region contaminated by UXO. Cambodia aims to be landmine free by 2025 in accordance with their obligation under Article 5 of the APMBC, but the demarcation of border territory with Thailand remains a challenge to the demining effort, and, according to the CMAA (2023), the country needs USD138 million to clear the landmines, of which the RGC is going to provide USD60 million. Reports claim that Cambodia is not on track to hit their 2025 deadline[12], likely due to these challenges.

The impact of EO contamination on Cambodia and its citizens has been, and continues to be, widespread and severe. The principal indicator of the direct impact of contamination is the number of casualties. According to data provided by the Cambodian Mine Action and Victim Assistance Authority (CMAA) – established in 2000, responsible for regulation, planning and coordination of HMA activities – the number of total casualties caused by landmines and UXO[13] in Cambodia is the highest of any country: approximately 65,000 casualties from 1979-2022, including 44 casualties in 2021, and 41 in 2022[14] (CMAA, 2023). According to the CMAA, there are now approximately 45,000 survivors of ERW in Cambodia.[15]
As important as casualties are as an indicator of harm, the impact of EO has impacted the lives of survivors and their communities far beyond that which casualty figures can depict. The physical, psychological, and

[11] The specific number of landmines laid in this period is unknown.
[12] Cambodia's original deadline to clear was on 1st January 2010 – they have made 2 requests for extension 10yr and 6yr respectively – their current deadline is 31st December 2025.
[13] Note that this does not consider the impact of improvised explosive devices and other weapon types.
[14] In 2022, 19 causalities were caused by landmines, 22 causalities were caused by ERW. 10 people were killed, 31 people were injured and (7 people amputated). 28 causalities were men, 12 causalities were boys under 18 years old and 1 casualty was a woman. – unpublished data provided by the CMAA, 2023.
[15] According to figures provided in June 2023 by H.E. Mao Bunnhath, Director of the Victim Assistant Department of the Cambodian Mine Action and Victim Assistant Authority (CMAA).

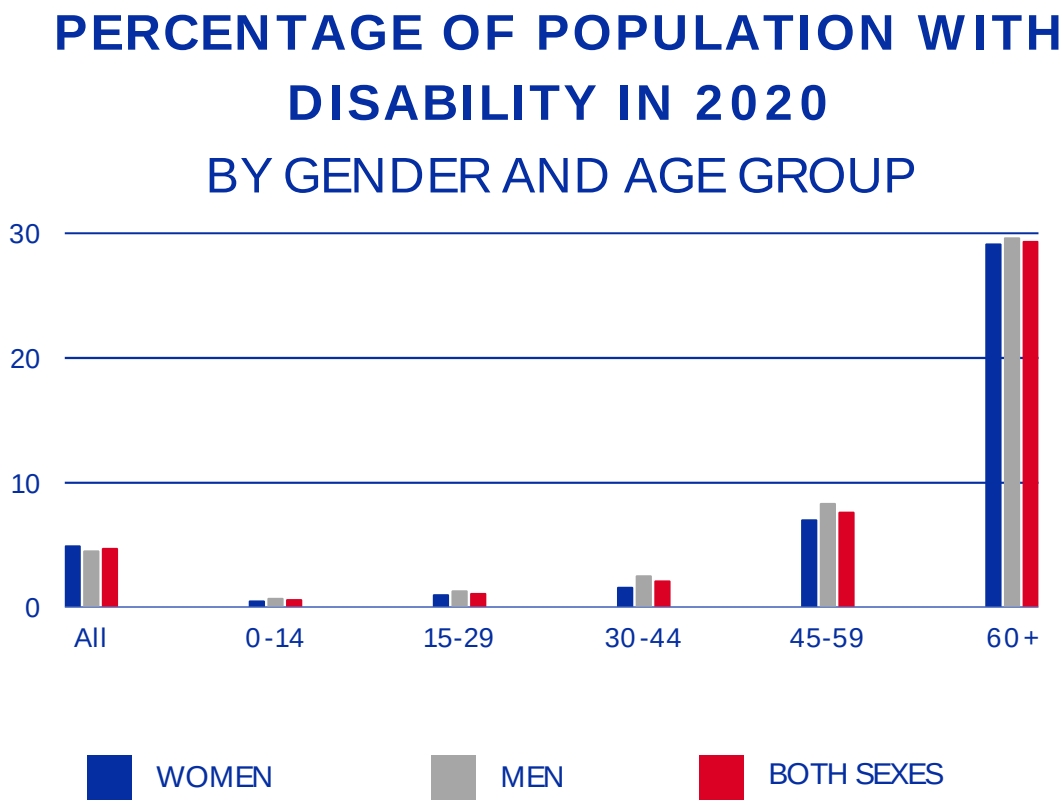
socioeconomic consequences of EO contamination for those injured and disabled by explosive ordnance (i.e. survivors) are often life-changing. The reverberating effect of harm, however, often extends beyond survivors. EO contamination and harm has disrupted the provision of food, medical aid, clean water, sanitation and other critical services and provisions. Although less intense today, due to the clearance effort, contamination has also compromised housing and infrastructural development, absorbed government resources, disrupted economic and social activity, and pushed people into poverty. Contamination in Cambodia has hampered stabilization, peacebuilding, reconciliation, infrastructure recovery and the return to normal life, as well as slowed down local, national, and regional development (United Nations, 2016, p. 2).

In defiance of the widespread and penetrative impacts of landmines and UXO on the country, Cambodia has seen rapid economic and infrastructural development since 1992, particularly after joining the Association of Southeast Asian Nations (ASEAN) Free Trade Area in 1999. During this time of rapid economic development, poverty reduction for landmine/ERW victims and people with disabilities has been one of the development goals of the RGC and a focus of various national policies and strategic plans (explored in the next section). As a result of this transformation of Cambodia in peacetime, poverty decreased from 47.8% in 2007 to 13.5% in 2014 (Asian Development Bank, 2021).

Despite the reduction of EO contamination and harm, and the correlating growth of the economy and declining poverty rate, Cambodia remains one of the poorest and most undeveloped countries in Southeast Asia, with 1,561USD gross domestic product (GDP) per capita (National Institute of Statistics and Ministry of Planning, 2021). Large disparities in living standards are also prevalent, especially between rural and urban areas (National Institute of Statistics and Ministry of Planning, 2021). One of the most adversely affected groups in Cambodia – as in other countries – are people with disabilities (Palmer, et al., 2019). Explored further within the context of Cambodia in the Situational Analysis below, people with disabilities are thought to be more likely to overpopulate the poor due to, among other factors, higher costs of living, restricted access to education, and fewer employment opportunities (see Sen, 2004; Filmer, 2008; Mitra, 2018; Mitra et al., 2013).

Exemplifying the additional healthcare requirements (and related costs) of people with disabilities to the RGC, the CMAA reports that thousands of Cambodians need ongoing prosthetic and physical rehabilitation support, many due to EO harm. In 2021, the annual Socioeconomic Survey by the National Institute for Statistics indicated that around 4% (approximately 722,643 people) of the total population of Cambodia were disabled in 2020 (National Institute of Statistics and Ministry of Planning, 2021). In the survey, 16,720 people reported that landmine/ERW and war injuries were the cause of their disability, constituting around 2.3% of the recorded population of people with disabilities and approximately 0.1% of the total population of Cambodia (ibid 2021). In addition to this 2021 survey, the 2008 Cambodian census revealed that rural areas had 5.8 times more people with disabilities than urban areas (National Institute of Statistics and Ministry of Planning, 2009). The census also revealed that areas that are heavily contaminated with landmines/ERW saw the highest rates of persons with disabilities. Although outdated, this data shows that contamination has a significant direct impact on many people with disabilities in Cambodia, and that many people with disabilities are living in rural areas with limited access to the services they are likely to require.
The Cambodian government has various obligations under international conventions and laws to mitigate the enduring impact of EO contamination both direct and indirect victims. The mechanisms to achieve this

have been well defined as VA. The next section outlines the responsibilities of the RGC in accordance with legally binding obligations that it has committed to.



National Institute of Statistics and Ministry of Planning , 2021

4. Situational Analysis
Victim Assistance in Cambodia

In line with the responsibilities of the RGC according to their commitments to international documents and considering the cross-cutting indicators of best practices and activities extracted from the conventions and documents in Appendix II, this section analyses the inclusiveness of VA frameworks in Cambodia.

The most relevant articles and paragraphs of the APMBC, the CRPD, the Oslo Action Plan, and IMAS 13.10 have been adapted and listed in Appendix II. Although unusual to include such important information in an Appendix, it would be impractical to list them in the main body due to the magnitude of the texts presented. This section, instead, summarises the responsibilities of VA stakeholders in Cambodia based on these documents, and builds a general understanding of the standard of inclusive VA that should be present in Cambodia in line with their commitments to the international conventions and the associated international guides and standards. As the relevant articles are used as a framework for analysis, the reader can refer to Appendix II for more detail on VA roles and responsibilities in Cambodia.

The first subsection explores the RGC's commitments to international conventions and the associated responsibilities. The second subsection reviews VA-relevant frameworks in Cambodia with an underlying focus on inclusivity, relating to funding, actors and institutions (and their roles and responsibilities), laws, policies, strategies, and action plans. The third subsection links the relevant frameworks to VA services. Finally, an analysis provides insight on how inclusive the frameworks related to VA services are in Cambodia.

4.1. Cambodia's Commitments and Responsibilities

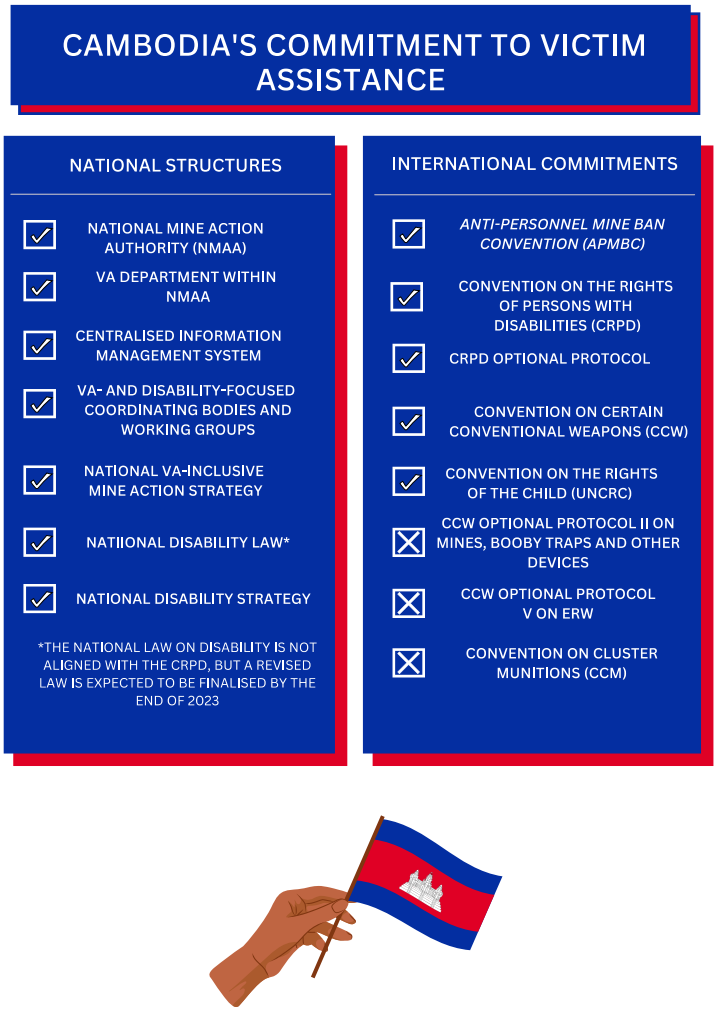
In line with the international conventions that Cambodia has ratified and acceded, the VA administrators in Cambodia have a mandate to identify and address the needs of the thousands of Cambodian citizens who have been directly and indirectly affected by EO. It is the principal responsibility of the RGC to ensure that a comprehensive range of suitable support and services are being implemented effectively to help victims recover and actively participate into society, as well as protect them from further harm. To indicate their commitment in this regard, the RGC have developed national structures to provide VA built on the foundation of international laws and conventions that they have signed and ratified (presented in the situational analysis).

The two most relevant international conventions to the provision of VA in Cambodia are the APMBC (signed in 1997, ratified 1999) and the CRPD (signed 2007, ratified 2012)[16]. To counter the direct humanitarian impacts of anti-personnel mines, victim VA was inaugurated as a concept in the APMBC – the first legally-binding international humanitarian convention to include it. The document declares that:

[16] The important distinction between signing and ratifying these treaties is that signing signifies a state's intention to implement the conditions of an international document domestically, and usually obliges them not to take actions that would undermine it, and ratifying makes the state's obligations accountable to international law. Once a treaty or convention is ratified, it must take active steps to implement the conditions of the document.

> "Each State Party in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims and for mine awareness programs. Such assistance may be provided, inter alia, through the United Nations system, international, regional, or national organizations or institutions, the ICRC, national Red Cross and Red Crescent societies and their International Federation, non-governmental organizations, or on a bilateral basis" (United Nations, 1997).

VA obligations were subsequently included in the Protocol on Explosive Remnants of War to the Convention on Prohibitions or Restrictions on the Use of Certain Conventional Weapons Which May Be Deemed to Be Excessively Injurious or to Have Indiscriminate Effects (CCW) and the Convention on Cluster Munitions (CCM) – neither of which Cambodia has ratified acceded.



Since the ratification of the APMBC, various associated documents have clarified and extended the definition of VA in mine action to include specific, implementable, activities to address the short-, medium-, and long-term needs of those who have experienced physical, psychological, or socioeconomic harm by EO, either directly or indirectly. One of the most important documents in developing the understanding of VA is the 2019 Oslo Action Plan. For the first time, clear and distinctive actions to assist victims of EO harm were detailed, expanding on the broad understanding introduced in the APMBC in 1997.

One of the Oslo Action Plan's 'best practices' for implementation of the plan's 50 actions is States' "efficient use of available resources, including through the use of the latest methodologies in line with the International Mine Action Standards (IMAS)" (Oslo Review Conference, 2019, p. 4). Although not created until 2021 (amended in January 2023), the United Nations Mine Action Service (UNMAS) International Mine Action Standards (IMAS) 13.10 on Victim Assistance provides clear language and structure for implementing the VA activities established in Oslo in 2019[17]. IMAS 13.10[18] serves as a unified and

[17] To view the IMAS 13.10 document, visit https://www.mineactionstandards.org/standards/13-10/.
[18] It should be noted that Cambodia, as a State Party to the APMBC, agrees to the Oslo Action Plan, and has declared support for IMAS 13.10.

comprehensive language tool for countries party to the APMBC, including Cambodia, and, therefore, its language is used by this report when analysing the VA systems and services in Cambodia.

Cross-referencing the Oslo Action Plan and IMAS 13.10, the primary VA sectors are categorised as follows:

Medical care: The Oslo Action plan requires Cambodia to provide emergency medical care, comprising of first aid/trauma aid, emergency evacuation, transport, and immediate medical care. Cambodia also has a responsibility to provide ongoing medical care for EO survivors, which, although not detailed in the Oslo Action Plan, includes ongoing treatment, surgeries, pain management, and monitoring of injuries.

Rehabilitation: Many survivors require prosthetic limbs, orthotic devices, or mobility aids (such as wheelchairs or crutches) to regain and improve independent mobility. Physical rehabilitation services, include physiotherapy and occupational therapy – including training for the use prosthesis and orthosis – that are vital to help survivors adapt to their new physical realities and improve their quality of life. Rehabilitation requires a multidisciplinary approach of services within the health sector. Under the Oslo Action Plan, States have a requirement to provide these comprehensive services to all EO victims, including those living in rural and remote areas.

Psychological and psychosocial support[19]: Survivors of mine and UXO accidents (and their families) often face mental health impacts following an EO incident, with more severe cases resulting in post-traumatic stress disorder (PTSD), depression, and anxiety (The Sir Bobby Charlton Foundation, 2022). Providing mental health support is a requirement of Cambodia under the Oslo Action Plan and, although only peer-to-peer support is mentioned, IMAS 13.10 suggests that states should also provide counselling by psychologists and psychiatrists and psychosocial support (cultural, social, and sporting activities).

Socioeconomic inclusion: The Oslo Action Plan (2019) requires that Cambodia creates an environment of economic, education, and social inclusion for mine victims through "access to education, capacity building, employment referral services, microfinance institutions, business development services, rural development and social protection programmes, including in rural and remote areas" (Article 39).

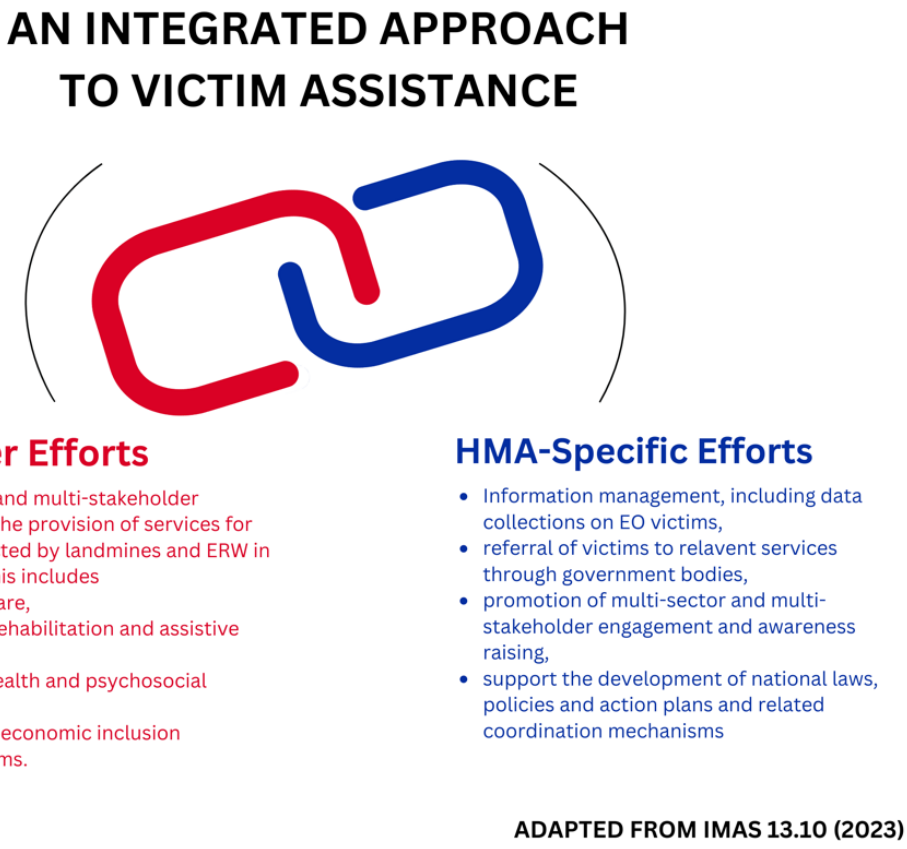
In addition to these services that are reviewed in this report, Cambodia also has a responsibility to ensure that **plans and mechanisms are in place to provide for the safety of survivors in situations of risk – armed conflict, natural disaster, humanitarian emergencies**.

Reflecting the often multifaceted and complex needs of victims, the mine action community has come to recognise that national VA programmes must be integrated with broader public structures and take a multi-sectoral and multi-stakeholder approach. At the fourth review conference in Oslo, 2019, States Parties agreed that VA should be integrated into "broader national policies, plans, and legal frameworks on the rights of persons with disabilities and support the realization of the Sustainable Development Goals

[19] This is referred to as Mental Health and Psychosocial Support (MHPSS) in this report.

(SDGs)"[20] (Landmine & Cluster Munition Monitor, 2021, p. 77). Accordingly, IMAS 13.10. distinguishes between the suggested activities of the specific HMA VA sector and those of the broader VA sector in an effective VA system: HMA VA should support the capacity of broad mechanisms to provide critical services and provisions to victims through cross-cutting activities such as information management, referral of victims to services, coordination of multi-sector actors, and awareness raising (explored further in the next section).

In accordance with the APMBC and the CRPD, the responsibility to provide VA services in Cambodia falls principally on the government, with HMA-specific support activities conducted by the NMAA, which, in Cambodia, is the CMAA. The HMA-specific efforts of the CMAA should be supported by the national mine action centre (the Cambodian Mine Action Centre (CMAC)) and other mine action operators, as well as survivor organisations and the United Nations. In accordance with the APMBC and the Oslo Action Plan and adapted from the roles and responsibilities presented in IMAS 13.10, the specific practices of these entities have been outlined in Appendix II.



Considering the standards presented in IMAS 13.10. and the context of Cambodia, broad actors (actors outside of the HMA sector[21]), primarily the RGC, are responsible for the provision of VA services in

[20] The SDGs are closely linked to the role of HMA and VA. See the GICHD report exemplifying the link here: https://www.gichd.org/fileadmin/GICHD-resources/rec-documents/The_Sustainable_Development_Outcomes_of_Mine_Action_in_Jordan.pdf

[21] Such as the Ministry of Health (MoH) and the Ministry of Social Affairs, Veterans Affairs and Youth Rehabilitation (MoSVY).

Cambodia. HMA-specific actors[22] should support broader structures through information management, advocacy and awareness raising (encouraging multi-sector and multi-stakeholder engagement) and supporting referral mechanisms by referring victims to service providers and vice versa (see Appendix II for more detail). By fulfilling these activities, one of the most important cross-cutting objectives of HMA VA stakeholders in Cambodia is to ensure that national frameworks (policies, plans, and programmes) are inclusive of EO victims and persons with disabilities.

This multi-layered national system should facilitate the structured and accountable implementation of inclusive services, built on a rights-based foundation, in line with international laws and standards. Under both the CRPD and the associated documents of the APMBC, there is a requirement of the government to facilitate the participation of EO victims and persons with disabilities at all stages (planning, implementation, evaluation) of programming and policy making related to VA. Any policies, laws, or programmes must also be designed with disability-, gender-, ethnic-, and age-inclusive considerations, in line with relevant international laws and standards.

Outlined in the APMBC and the CRPD and associated documents, the international community should support and complement the efforts of the RGC to establish inclusive, effective, suitable, and sustainable programmes and policy to support victims and persons with disabilities. This support should build the capacity of the CMAA and the national HMA system, while also enhancing the capacity of broader government institutions (such as MoH and MoSVY) and subnational communities and organisations. Examples of this capacity-enhancing support includes training of staff, resource mobilisation, direct provision of services, advocacy, and monitoring and evaluation. The international community should also establish and enhance the development of national policies, key mechanisms, and institutions relevant to VA. The United Nations (UN) has a special responsibility to ensure that the APMBC and the CRPD are upheld in Cambodia, and, in accordance with this responsibility, has a defined set of responsibilities (advocacy, capacity building, monitoring, and evaluation) in Cambodia that reflect the United Nations Policy on VA in Mine Action - outlined in Appendix II.

Both government and non-government VA stakeholders must be aware of the rights of EO victims and persons with disabilities under the international conventions that Cambodia has ratified and acceded, utilising them to guide their work to protect and promote these rights. The CRPD, which focuses on general disabilities but references victims of indiscriminate weapons, for instance, is a vital tool for stakeholders of both HMA-specific and broader VA stakeholder, including EO survivors and EO survivor organisations. It serves as the foundation for much of the law and policy relevant to survivors with disabilities, thousands of which live in Cambodia (according to data provided by the CMAA (2022)[23].

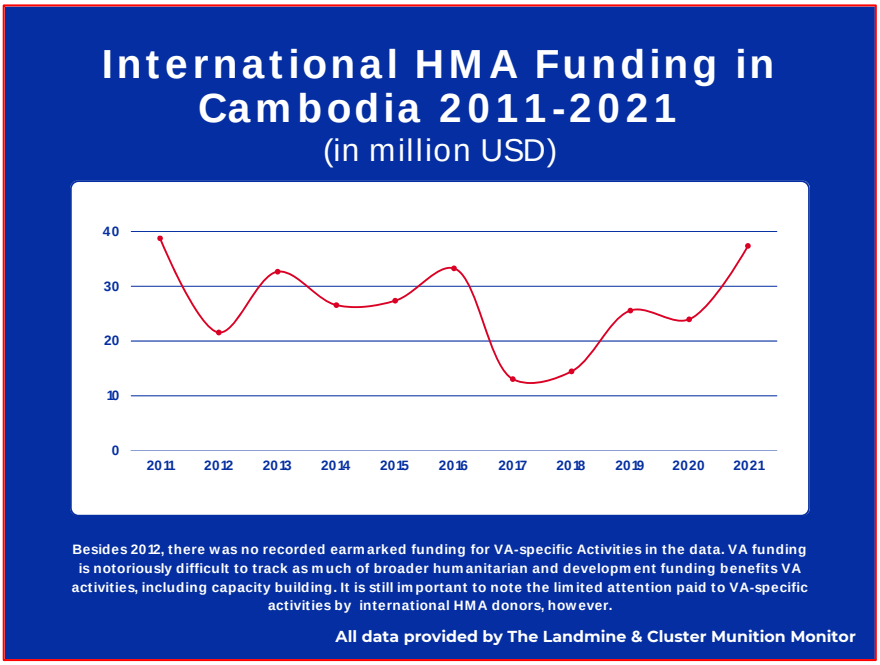
Other documents that reinforce the rights of EO victims and persons with disability that Cambodia has ratified/acceded include the Convention on the Rights of the Child (UNCRC), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Beyond the APMBC, these are invaluable tools that HMA VA stakeholders in Cambodia must

[22]Such as the CMAA and mine action operators.
[23] The CRPD applied to the four difference service areas (medical care, physical rehabilitation, MHPSS, and socioeconomic inclusion) can be found in Appendix II.

draw upon to ensure that mine victims are considered in national frameworks (policies, laws, strategies, action plans) and mechanisms (services, referral systems, coordination) of VA.

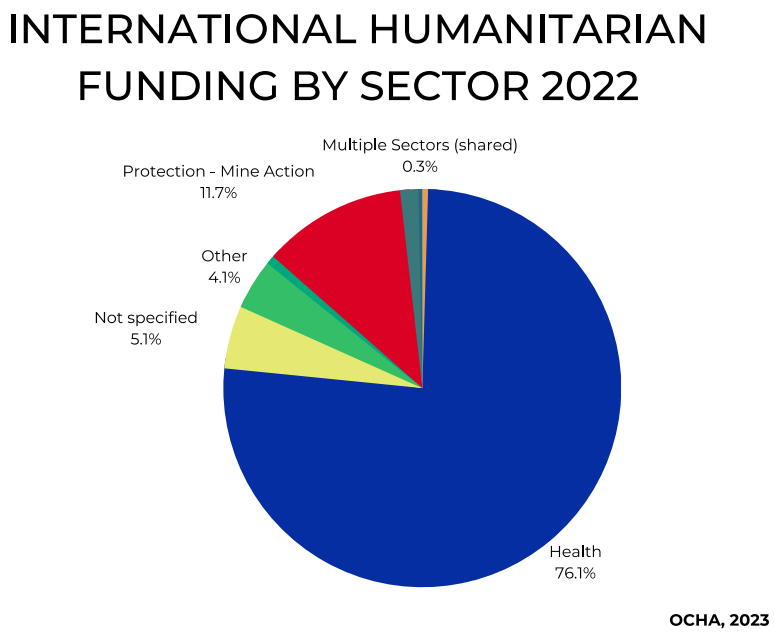
4.2. Cambodia's Victim Assistance System

The APMBC requires States in "a position to do" to "provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims and for mine awareness programs" (United Nations, 1997). Action 1 of the Oslo Action Plan builds on this, directing states that are party to the Convention to demonstrate national ownership by 'maintaining interest at a high level' in fulfilling Convention obligations, empowering and providing state entities with human, financial, and material capacity to carry out their obligations, implementing VA in the most inclusive, efficient and expedient manner possible with plans to overcome any challenges that needs to be addressed (Oslo Review Conference, 2019). In line with the APMBC and the Oslo Action Plan, Cambodia has signalled a willingness to take national ownership through the development of appropriate and comprehensive laws, policies, and strategies, but VA institutions run by the RGC are limited in capacity and output: all the VA stakeholders from the 19 government and non-government organisations interviewed commented on the decline of international support and the lack of funding in the public system (the impacts of which will be explored further in the next subsection).



According to Cambodia's National Mine Action Strategy (NMAS) 2018-2025, USD 46 millions is required to realise the goals envisioned for risk education, advocacy, sector management, and VA (RGC, 2017). How much of this is required specifically for HMA VA activities is not specified. Considering the limited amount of international and national humanitarian funding allocated to victim assistance services (and even that for broader humanitarian aid), this is concerning. According to data presented in the 2021 Landmine Monitor, there was an (approximate) 33% reduction in international donations for HMA activities in Cambodia from 2011 (USD35.8 millions) to 2020 (USD23.9 millions) (Landmine & Cluster Munition Monitor, 2021). Following a steady reduction of international HMA funding in Cambodia over 10 years, there was a leap back up to USD37.3 million in 2021. It is difficult to identify how much of this funding benefits victim assistance efforts (such as data collection and coordination) in Cambodia, as, according to the Landmine & Cluster Munitions Monitor (2022), the country received no international

funding earmarked for VA-specific activities (p.107)[24]. The increased HMA funding will - according to interviews with the CMAA, CMAC and two leadership members mine clearance organisations - almost entirely go to clearance efforts to increase the probability of achieving Cambodia's 2025 'mine free' deadline. In the 2022 APMBC Intersessional Meetings, the CMAA revealed that the RGC is committing USD75,000 annually to strengthen VA mechanisms.



It is difficult to track international funding for broader VA mechanisms in Cambodia due to the multitude of avenues by which this can be achieved. One useful indicator, however, is the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) financial tracking service. This UNOCHA tool reported that only 11.7% (USD1.7 million) of reported[25] international humanitarian funding for Cambodia in 2022 (USD14.8 millions) was earmarked for mine action activities (including VA), but other areas likely to directly benefit EO victims such as food security, health, and water sanitation and hygiene (WASH) received over 80% of funding ((OCHA, 2023). Although this commitment to broad VA services is encouraging, the amount of humanitarian funding received by Cambodia in international humanitarian funding fell from USD37.5 million in 2020, to USD 27.6 million in 2021, and then fell again to USD 14.8 million in 2022. This is a reduction of 61% from 2020 to 2022 (ibid. 2023). The consensus among interviewees working for international organisations in the humanitarian and development sectors is that the drop in humanitarian funding for Cambodia in 2022 from the international community is due to the redirection of resources to support countries' recovery from the COVID-19 pandemic, and to mitigate the humanitarian crises caused by major conflicts such as Afghanistan and Ukraine[26]. When asked about this reduction in funding, interviewed representatives from both government and non-government entities unanimously agreed that the reduction in support from the international community over recent years has hampered their ability to provide quality and comprehensive services, and carry out other activities to support victims of EO and persons with disabilities.

The CMAA plays a key role in encouraging the influx of funding from the international community for HMA-specific and broader VA services by disseminating information at international events on national VA activities and the need for additional resources to support EO victims. Signalling commitments is also

[24]The amount of global funding earmarked for VA activities from 2010 to 2020 averaged at about 6% (approximately USD30 millions per year on average) – less than Cambodia alone received for HMA activities in 2021.
[25] Although a useful tool, the UNOCHA financial tracking service likely under-represents international humanitarian funding in Cambodia.
[26] This claim was corroborated using data on humanitarian funding: Ukraine reportedly received almost USD17 billions in humanitarian funding in 2021 alone – almost half of all humanitarian funding that year (Institute for the World Economy, 2023).

achieved by establishing national policy and strategy that reflects international VA objectives. The Royal Government of Cambodia, for instance, made a special effort to signal its commitment to the Oslo Action Plan (Action 6) to the international community by endorsing the 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs) at the UN General Assembly in 2015. The SDGs are complementary to the aims of the Mine Ban Treaty. They offer opportunities to bridge relevant frameworks in relation to mine/ERW VA to fulfil commitments relevant to VA "in the context of disability rights and the SDGs." (Landmine & Cluster Munition Monitor 2022, p.75). As well as working to localise all 17 goals in national policy, the RGC went a step further and added SDG 18 – "end the negative impact of Mine/ERW and promote VA" (Royal Government of Cambodia, 2018). In addition, the Cambodian SDGs (CSDGs) reference five targets and two indicators related to persons with disabilities.

Establishing national laws, strategies, and policies that reflect international documents and are inclusive of EO victims and persons with disabilities is important to signal commitments but plays an even more important role in creating a legal (rights-based) framework upon which services and protective mechanisms can be implemented. A non-exhaustive list of key active laws and policies documents underpinning VA in Cambodia are:

Law on the Protection and the Promotion of the Rights of Persons with Disabilities (Disability Law) 2009

National Disability Strategic Plan (NDSP) 2019-2023

National Mine Action Strategy (NMAS) 2018-2025

Cambodian Mine Action Standards (CMAS) 2022

NMAS Three Year Implementation Plan 2021-2023

Health Strategic Plan (HSP) 4 2021-2030

National Strategic Development Plan (NSDP) 2019-2023

National Social Policy Protection Framework (NSPPF) 2016-2025

Education Strategic Plan (ESP) 2019-2023

Social Protection Policy Framework (SPPF) 2016-2025

Rectangular Strategy for Growth, Employment, Equity and Efficiency: Building the Foundation Toward Realizing the Cambodia Vision 2050, Phase Four (2018)

Cambodia Sustainable Development Goals (CSDGs) Framework 2016-2023

Although there is a strong collection of frameworks in Cambodia upon which to implement VA, challenges remain. Firstly, the Disability Law was adopted before Cambodia's ratification of the CRDP and is not suitably aligned with it. The Disability Law's language, including in the definition of disability, requires revision – a revised law is anticipated for the end of 2023 thanks to the efforts of the Cambodian Disability Action Council (DAC), which has developed its understanding through workshops with the UN. Article 49 of the current version of the Disability Law states that "All provisions of international treaties relating to the laws on the protection and the promotion of the rights of persons with disabilities to which the Kingdom of Cambodia is a party shall be implemented together with this national law. In case of any provisions that contradict the provisions of this law, the provisions of those international treaties shall be considered as the principle provisions." (Royal Government of Cambodia, 2009). Bolstering this, the National Mine Action Strategy 2018-2025 states that a "comprehensive legislative and policy framework to guarantee the rights and address the needs of people with disabilities" will be established (Royal Government of Cambodia, 2021).

Functions of Key Victim Assistance Stakeholders in Cambodia

CMAA	Responsible for HMA victim assistance activities in Cambodia, they collect data, support referral mechanisms, and raise awareness on the rights and needs of landmine and ERW victims, advocating for the consideration of victims in broader mechanisms.
MoSVY	Heads all the State rehabilitation*, disability affairs, and social protection and inclusion. Responsible for the formulation and implementation of the National Disability Strategic Plans, and policies related to assistance and protection.
DWDP	Under MoSVY, the DWPD leads and manages all disability-related work.
DRA	Monitors and promotes implementation of Disability Law: inspects public and private institutions to ensure compliance, provides legal consultations, mediates to resolve conflicts, and files complaints in cases of violation of the Law.
PwDF	Fund the implementation of programs to provide services for people with disability (health, rehabilitation, education), and manage the rehabilitation services and centres. They also promote improved welfare systems and inclusion of persons with disabilities and collect fines from institutions that do not comply with the Disability law.
DAC	Provides technical, coordination and advisory services on disability and rehabilitation. Responsible for establishing disability working groups within relevant ministries and institutions, and DACs in each municipality and province. Responsible for the implementation, monitoring, and evaluation of national disability policy, law, and action plans.
MoH	The MoH manages the operation of all public hospitals and healthcare centres. It also leads the formulation and implementation of health policy, including the Health Strategic Plans (HSPs).

Beyond its language, an institutional and systematic challenge of inclusive VA in Cambodia mentioned by over 90% of interviewees, is the weak implementation of the 'Disability Law', as well as other policies and strategies that underline the victim assistance system. A thematic analysis of interviews showed that the most prevalent perceived causes of weak implementation are limited resources, a lack of understanding and expertise on legislative and policy implementation – especially at the subnational level, a lack of disability awareness among the general population, and the lack of monitoring and enforcement, and a lack of a detailed cost analysis and forecasting mechanisms.

Exemplifying these issues, the NDSP 2019-2023 sets out comprehensive objectives to: increase employment and economic security; increase access to healthcare and rehabilitation services; provide access to education and technical and vocational training; improve accessibility; increase equal participation of persons with disabilities; increase access to justice, rights and freedoms; ensure gender equality; reduce risks and impacts caused by disasters; and strengthen cooperation at national and international levels and ensure that data and statistics on disability are reliable and comparable. The NMAS 2018 -2025 claims that "to support Mine/ERW VA, CMAA is the coordination mechanism under the leadership of the Cambodian Prime Minister to mobilize resources including technical and financial assistance as well as psychological support for the family" – supporting the broader disability objectives of the NDSP. However, due to the impact of the COVID-19 pandemic and an economic slowdown, senior representatives from the MoH, MoSVY, the DAC, the Persons with Disability Foundation (PwDF) and the CMAA all claimed in interviews that the implementation of VA services under both these strategies had not been funded and implemented sufficiently. The same claim was made by the team evaluating the impact of the NDSP 2019-2023, which stated that, largely because of COVID-19, the implementation of this plan was not possible, claiming that it was only disseminated by the DAC to three out of 27 RGC ministries, and that only "a few" of the 198 indicators for measuring and evaluating implementation had been collected. According to one interviewee helping to develop the Cambodian Mine Action Standards, the 'good framework, poor implementation' issue is seen across Cambodian policy, giving the example of traffic laws: "traffic laws require you to stop at red lights and wear a seat belt, but, especially outside of the city, people don't follow these rules".

To implement the stated laws, policies, and strategic plans, national structures and institutions are in place to address the needs of survivors, including emergency care, long-term physical and psychological care and rehabilitation, social and economic inclusion, education, and social protection and reintegration. As outlined above, the three core ministries related to the coordination of VA are the CMAA (HMA-specific), MoSVY (broad) and the MoH (broad). In addition to these key coordinating bodies of the government, other institutions play important roles in the functioning of the VA system:

The Ministry of Education, Youth, and Sport (MoEYS) – responsible for implementing education to children and adults, with specific institutions (the Special Education Department and the National Institution for Special Education) responsible for the provision of special and inclusive education to persons with disabilities.

The Ministry of Economy and Finance (MoEF) – responsible formulating and implementing economic and financial policies to support sustainable development, fiscal stability, and the efficient use of resources in the country. Forms the national budget and allocated finances to each ministry.

The Ministry of Information (MoInf) – responsible for ensuring that information is provided to persons with disabilities in line with the Access to Information Law.

The Ministry of Interior (MoI) – as the chair of the National Committee for Subnational Democratic Development in Cambodia, the Minister of the MoI can influence subnational EO victim and disability-inclusive development and decision-making process.

The Ministry of Labour and Vocational Training (MoLVT) – implements vocational training in its over-30 vocational training centres.

The Ministry of Planning (MoP) – responsible for collecting, analysing, and disseminating data through its socioeconomic surveys, and supports the implementation of the IDPoor programme (more detail in the next subsection).

The Ministry of Women's Affairs (MoWA) – promotes and protects the rights of women through economic empowerment and access to education. It also provides vocational training and small grants through its 13 Women's Development Centres. It also oversees implementation of the third National Action Plan to Prevent Violence Against Women 2019-2023, which includes the prevention of all forms of violence against women and girls with disabilities.

According to obligations under the APMBC, and the direction of the Oslo Action Plan and IMAS 13.10., the primary role of the **CMAA** in Cambodia, as the NMAA, is to support broader mechanisms for VA services, which are run by the government ministries – especially MoSVY and the MoH – and NGOs and civil society actors. To enhance comprehensive frameworks that have already been established in the country, the CMAA should focus on the collection and dissemination of data (in collaboration with other data collection efforts), raise awareness and champion the representation and inclusion of EO victims, and coordinate efforts to support EO victims through broader policy. In addition, the CMAA should continue to ensure that EO casualties receive emergency care and, along with existing survivors, support referral mechanisms, referring survivors to services provided by the RGC and NGOs.

In line with its responsibilities according to international conventions and standards, at a national level, the CMAA works to improve the understanding of victims' needs, monitor progress of programmes, and raise awareness through continued data collection, analysis, and dissemination. To this end, according to representatives from the CMAA victim assistance team, the USD75,000 in funding applied to HMA-specific VA activities has contributed to the pilot of a 'Quality of Life Survey' (QLS) facilitated by their 25 volunteer survivor networks, which, in 2021 and 2022 (in partnership with MoSVY and PwDF), conducted interviews with 5,700 survivors and persons with disabilities (2,280 and 3,420 respectively), including 1,860 survivors (information provided by the CMAA (2023)[27]. The QLS survey records socioeconomic indicators such as education, healthcare, mental health, social inclusion, employment, and access to clean water. The survey is conducted on a digital tablet and allocates a 'personal circumstances' score to an individual. If this score falls below a certain threshold, the CMAA investigates and, in cooperation with its partners, refers that individual to suitable assistance. According to the CMAA, using tablets instead of paper reduces the administration workload by 60-70% and limits the risk of missing, duplicated, or incorrect data. According to the 2022 survey results, "most of survivors met received assistances and few of them lack access to services" (ibid., 2023). The CMAA disseminates the information it has analysed to service providers and policymakers in Cambodia and presents regularly to VA stakeholders in the country through technical working groups, attended by representatives from dozens of government a non-government VA stakeholders (HMA-specific and broad). The QLS builds on the CMAA's existing Mine/ERW Victim Information System (CMVIS), enhancing the country's ability to target its services. In addition to their information-sharing and coordination efforts, the CMAA also

[27] The number of landmine survivors captured by the QLS jumped from 567 in 2020 to 1,295 in 2021.

organised a persons with disabilities and EO survivor forum at the subnational level in 2022 to discuss the needs of those disabled by EO – 278 people attended, and organised a meeting with 35 self-help groups attended by 189 EO survivors and persons with disabilities (information provided by the CMAA, 2023).

Not an HMA actor, **MoSVY** is principally responsible for protecting and promoting the welfare of persons with disabilities in Cambodia (which means it is responsible for supporting thousands of survivors) through various associated departments and coordinating bodies. Exemplifying this responsibility, in MoSVY's NDSP 2019-2023, it states that, through the work of MoSVY's Department of Welfare for Persons with Disabilities (DWDP), the majority of persons with disabilities will gain access to skills training and rehabilitation, and over 20,000 people will receive disability allowance from the government (Royal Government of Cambodia, 2019).

Closely associated with MoSVY, **the DAC** – consisting of Prime Minister Hun Sen as Honorary President, four representatives of Organisations of Persons with Disabilities (OPDs) (two male, two female) and one representative from an NGO in the disability sector – is responsible for providing technical advice on disability and rehabilitation. The DAC also has the responsibility to prepare the NDSP and promote implementation, monitoring, evaluation and reporting on implementation of policy, plans, and laws related to disability (UNPRPD, 2021). In the past decade, there has been significant improvement in the coordination and capacity of national level stakeholders, with the DAC being granted a significantly increased budget, capacity, and influence (ibid., 2021).

Along with the DAC, the **PwDF** was established in the Disability Law (2009) as a body to manage rehabilitation services and centres, as well as the funding and implementation of other programmes to provide services for people with disabilities, including socioeconomic. The PwDF, which is made up of representatives from the various ministries and institutions, also collects fines if the Disability Law is violated, but, according to various interviewees, including the Director of the PwDF, they were not aware of the PwDF or the Disability Rights Administration (DRA) ever collecting fines for non-compliance with the law, likely due to a lack of resources and/or monitoring mechanisms.

Besides the institutions associated with disability, the **MoH** is responsible for providing healthcare services to the entire population, including EO victims and persons with disability.

As with international funding, it is difficult to track funding for EO victims at the national level, as **Cambodia's national budget** does not include a specific budget allocation for EO victims or persons with disabilities. The budget is allocated to ministries in charge of disability affairs, health, education, employment, and other key areas that EO victims and persons with disabilities will benefit from. In 2020[28], three ministries responsible for education received 20.3% of the budget, the MoH received 11.6%, MoSVY received 8.7%, and the ministry responsible for labour and training received 1.8%. Five percent (USD17.6 millions) of MosVY's budget was allocated to social welfare programmes, while 90% USD289.2 million went to social security and rehabilitation (UNPRPD, 2021). The MoEF reported that, in 2018, ten ministries included a disability-specific budget in their strategy, including the MoWA (USD50,000), the MoEYS (USD150,000) and the Ministry of Tourism (USD 20,000). The budget for physical rehabilitation services

[28] It was not possible to gather more recent disaggregated data, but the budget for 2023 is USD 9.64 billions – the percentage share can be used as an indicator to estimate how much each ministry will receive in 2023.

through the PwDF increased by 51%, from 2013-2016 (ibid., 2021). There is no forecast/projected budget indicated in the NDSP2 to realise its objectives.

At the subnational level, one of the most relevant actors is the **MoSVY Provincial Office and District Office of Social Affairs, Veterans and Youth Rehabilitation (PoSVY/DoSVY)**. The quality and influence of their functions varies from area to area according to the MoSVY representatives interviewed. According to interviews, there are significant capacity and expertise shortfalls, with some subnational structures relying solely on **community leaders and village chiefs** to address EO victims' and disability issues.

Alongside the government's public services, largely managed by the MoH and the MoSVY, **NGOs** continue to provide services include the International Committee of the Red Cross (ICRC), Humanity and Inclusion (HI), Australia-Cambodia Cooperation for Equitable Sustainable Services (ACCESS), EXCEED Worldwide, and the UNDP. Many Cambodian NGOs also support survivors at the local level, including SAORI Organisation, Disability Development Services Programme (DDSP) and various OPDs. These national and international organisations provide health and rehabilitation services, vocational training and economic support, rights promotion and protection, and psychological support. NGOs run many of the services for EO victims and persons with disabilities, including the provision of a large majority of the prosthetic, orthotics, rehabilitation, and other services currently conducted in the physical rehabilitation centres (PRCs). They also support and advise on the development of laws and policies and support the capacity of public services and institutions (outlined in more detail in the next subsection).

The UN - predominantly through the UNDP, the United Nations Children's Fund (UNICEF), the United Nations High Commissioner for Refugees (UNHCR), and the World Health Organisation (WHO) – supports work related to VA for EO victims, including the strengthening of the capacity of national and subnational service providers (across medical care, socioeconomic inclusion, and rehabilitation). The UNDP is especially involved with HMA and EO VA through its 'Clearing for Results' programme, and assistance for persons with disabilities as outlined in its Country Programme Document 2019-2023. The UNDP, UNICEF, and the WHO, alongside the Australian Red Cross and various RGC entities are being funded by The Australian Government Department of Foreign Affairs and Trade (DFAT) to implement projects to assist EO survivors (Landmine Survivor Assistance Programme) and improve the quality of life for persons with disabilities (Disability Rights Initiative Cambodia).

DFAT is also supporting persons with disabilities through their **ACCESS** 2018-2021, in which they committed USD15 million to improve the health and socioeconomic outcomes of persons with disabilities and improve coordination and management of the physical rehabilitation centres. Many stakeholders stated in interviews, however, that the end of this three-year project has largely been a failure, especially in relation to the development of the PRCs being managed by the PwDF – pointing to the end-of-programme evaluation for evidence, which corroborated this claim[29].

OPDs and EO Survivor Organisation - non-governmental organisations run by those they represent (persons with disabilities and EO Survivors) act as an advocacy body and an intermediary between policy makers and persons with disabilities. In some cases, they distribute resources and provide other support to their communities. The largest OPD in Cambodia, the Cambodian Disabled Persons Organisation (CDPO)

[29] https://www.dfat.gov.au/sites/default/files/access-end-of-program-evaluation.pdf

has a network of 75 member organisations across all 25 provinces in Cambodia, 15 of which have offices in subnational government buildings, and are connected to 1,000 self-help group consisting of approximately 20,000 members (UNPRPD, 2021). The CDPO also has a permanent position in the DAC and plays an active role in decision-making, which enables them to influence policies and programmes at the national level, as well as influence the revision of the disability law. Persons with sensory and psychological disabilities are largely marginalised in Cambodia. For instance, only ~2,000 of ~60,000 deaf people in Cambodia know sign language (ibid.,2021), making it difficult for them to communicate with others and is one of the main reasons why they do not have an OPD.

Interviewees representing NGOs working directly with local communities stated there is a desperate need to improve awareness of sensory and psychological disabilities in Cambodia. In 2021, All Ears Cambodia[30] - a local NGO that has been working in partnership with the RGC for 17 years to provide specialist ear and hearing care services to over 28,000 people - estimated that two million people in Cambodia have disabling deafness, most of whom live in rural areas (World Health Organisation, 2021). All Ears Cambodia label hearing loss as the 'invisible disability', because of the lack of visible symptoms and because it has long been stigmatised in communities and ignored by policy makers. The executive director of one community-based rehabilitation programme, DDSP, also supported the claim of All Ears Cambodia, stating that the participation of those with physical disabilities is far greater than those with sensory disabilities – and this correlates with the level of understanding about the respective categories of disability.

Those who are deaf are not the only group to lack mechanisms to access information. According to information provided DDSP, many EO victims and persons with disabilities, especially those living in rural and remote areas, do not have access to the internet, television, or radio, meaning that they are isolated from national broadcasts. Because of this, according to DDSP, many people with disabilities struggled to access information about public assistance related to the COVID-19 pandemic, with those who could hear largely relying on radio broadcasts for information. In addition, according to the CMAA, there is not a centralised online directory accessible to EO victims and persons with disabilities to identify and access services. Beyond the community level lack of accessible information, according to an interviewed persons with disabilities working for the RGC, there is a barrier for persons with disabilities to meaningful participation in discussions.

In addition to the lack of access to information, there is a severe lack of accessible transport and public places, despite it being the subject of many of the articles in the CRPD, and of Chapters 5 and 6 of the Disability Law. The director of CMAC stated in an interview when discussing CMAC's interactions with communities, that "accessibility is the backbone of disability inclusive development: infrastructure, transportation, communication. [The RGC] cannot provide quality services without providing accessible services." According to representatives of the CMAA and various UN and consulting bodies to the RGC, the development of policies and laws that directly or exclusively relate to EO survivors and persons with disabilities OPDs are inclusive of persons with disabilities, but broader policy and programming at the national and subnational level are not disability inclusive, especially for those with sensory and psychological disabilities, who have the least public understanding, support, representation, and, are therefore, the most vulnerable. According to various organisations, including the CMAA and CMAC, the public understanding of disabilities is low from the community – reflected by the lack of their inclusion in broader (non-disability-

[30] http://www.allearscambodia.org/caring_about_ears/ear_health_cambodia/index.html

specific policy) – in both the public and private sectors. There needs to be greater representation of persons with disability in policy documents, action plans, and law.

It is the hope that, following the implementation of the NDSP and the Access to Information Law, and the revision of the Disability Law, physical access and access to information will improve, but this requires financial commitments by national and international actors - the UNDP is working to improve disability inclusion (UNDP, 2023). In the meantime, persons with disabilities lack meaningful participation of persons with disabilities in the development, implementation and monitoring of policies, laws, and strategic plans remains limited.

A representative from the CMAA, highlighting the importance of participation, stated in an interview: "Before you do anything, you need to listen to the voice of the victim. This is the most important thing. This needs to happen [at the] top and then everyone else will follow".

4.3. Cambodia's Victim Assistance Services

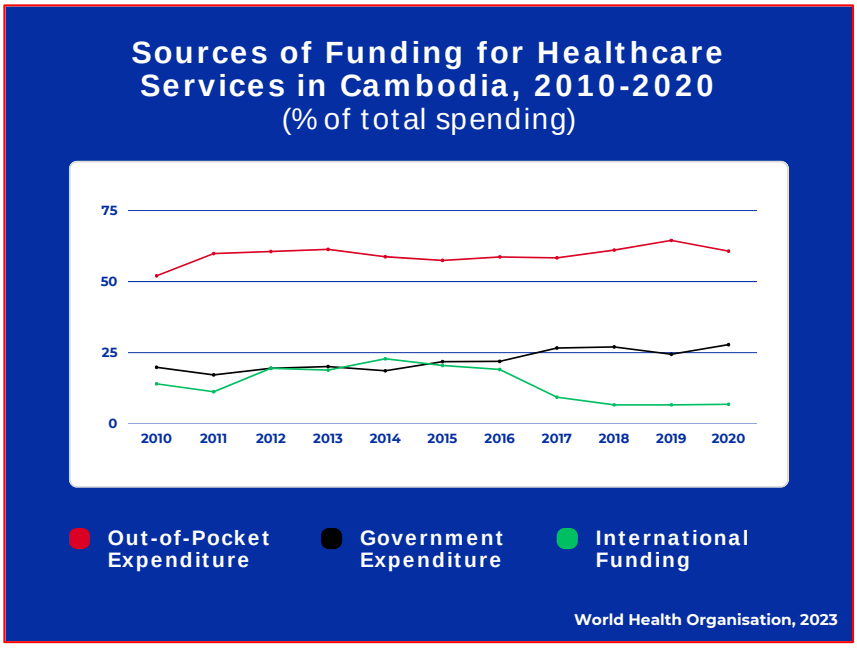
There were 41 casualties caused by EO in 2022 alone, adding to the thousands of existing EO survivors in Cambodia. As established, to mitigate the short- medium- and long-term impacts of EO harm, there are various broad and mine action-specific VA mechanisms in the country. The intentions of the RGC signalled by their international commitments and national frameworks largely aligns with their responsibilities to the APMBC and the CRPD, but it is more difficult to ascertain from existing research and data, how well Cambodian legal, policy, and programmatic commitments translate into implemented services EO victims and persons with disabilities, especially at the community level.

Despite these difficulties, this section analyses the four categories of VA services provided by government and non-government stakeholders: medical care, MHPSS, physical rehabilitation, and socioeconomic inclusion and social protection. The aim of this subsection is to build an understanding on the inclusivity of EO victims and persons with disabilities in the policy and strategy of the RGC and Cambodia's humanitarian and development partners, as establish a consensus on the system's effectiveness.

4.3.1. Medical Care

Healthcare services in Cambodia are largely implemented under the framework of the Health Strategic Plan (HSP). HSP3 ran from 2016-2020, preceded by HSP4 2021-2030 in 2021, but HSP4 has not yet been published in English, so this report refers to the impact of HSP3. Regarding the inclusivity of services, a key working principle of the HSP is equity: "Removing socio-cultural, geographical, financial, and bureaucratic barriers in access to, and utilization of, quality health services, especially in relation

poor and vulnerable people, including persons with disabilities, ethnic minorities and elderly" (Royal Government of Cambodia, 2016, p. 64). Aligning with Strategic Objective 2 of the NDSP2 to 'increase access to health and rehabilitation services', Strategic Intervention 21 of HSP3 was to "build, upgrade, renovate and maintain public health facilities according to the updated Health Coverage Plan and Health Infrastructure Building Briefs" with the desired outcome being "increased access to and expanded coverage of health" (ibid, 206, p. 96).



Supporting the HSP, other key healthcare plans include the Health Workforce Development Plan 2021-2030 and the National Strategic Plan for Pre-service Education in the Health Sector in Cambodia 2020–2025. These two plans are aimed at tackling the workforce shortage in the healthcare sector in Cambodia with less than two doctors and less than 10 nurses per 10,000 people (The World Bank, 2022) – significantly below the average of nine doctors and 19 nurses per 10,000 people among low- and lower-middle-income countries in the East Asia and Pacific region (ibid., 2022). According to The World Bank, which is providing USD 15 million in credit to the National Strategic Plan for Pre-service Education, "doctors typically work at secondary- and tertiary-level facilities, while primary care facilities are almost entirely staffed by nurses and midwives" (The World Bank, 2020). In additional, most practitioner doctors work at the provincial level, while most specialists are deployed to hospitals at the central (national) level, with very few healthcare doctors working locally (ibid., 2020). The Pre-Service Education project aims to improve the human resources within the MoH and strengthen the governance of health professional education, including regulations and standardization for health professionals' education. The project will also "support the development and delivery of competency-based training programs by the University of Health Science and Regional Training Centres in six health professional programs: general medicine, dentistry, pharmacy, nursing, midwifery, and laboratory" (The World Bank, 2020).

According to the CSDGs, the RGC aims to achieve universal health coverage, providing every Cambodian citizen with affordable and high-quality healthcare (Royal Government of Cambodia, 2017, p. 29). The National Social Protection Working Group – led by the MoEF – is responsible for the development of social health protection. Currently, Cambodia has three types of insurance that cover three groups: the Health Insurance Scheme for Poor People and for Children (Health Equity Fund (HEF); Community-Based Health Insurance Schemes; and Private Health Insurance. None of these schemes target persons with disabilities, but persons with disabilities are able to apply. The RGC have said that they aim to extend health insurance to persons with disabilities if possible (Royal Government

of Cambodia, 2017, p. 31), and the introduction of the identification for persons with disabilities (explored later) grants persons with disabilities access to certain healthcare services for free.

PUBLIC HEALTHCARE STRUCTURE IN CAMBODIA

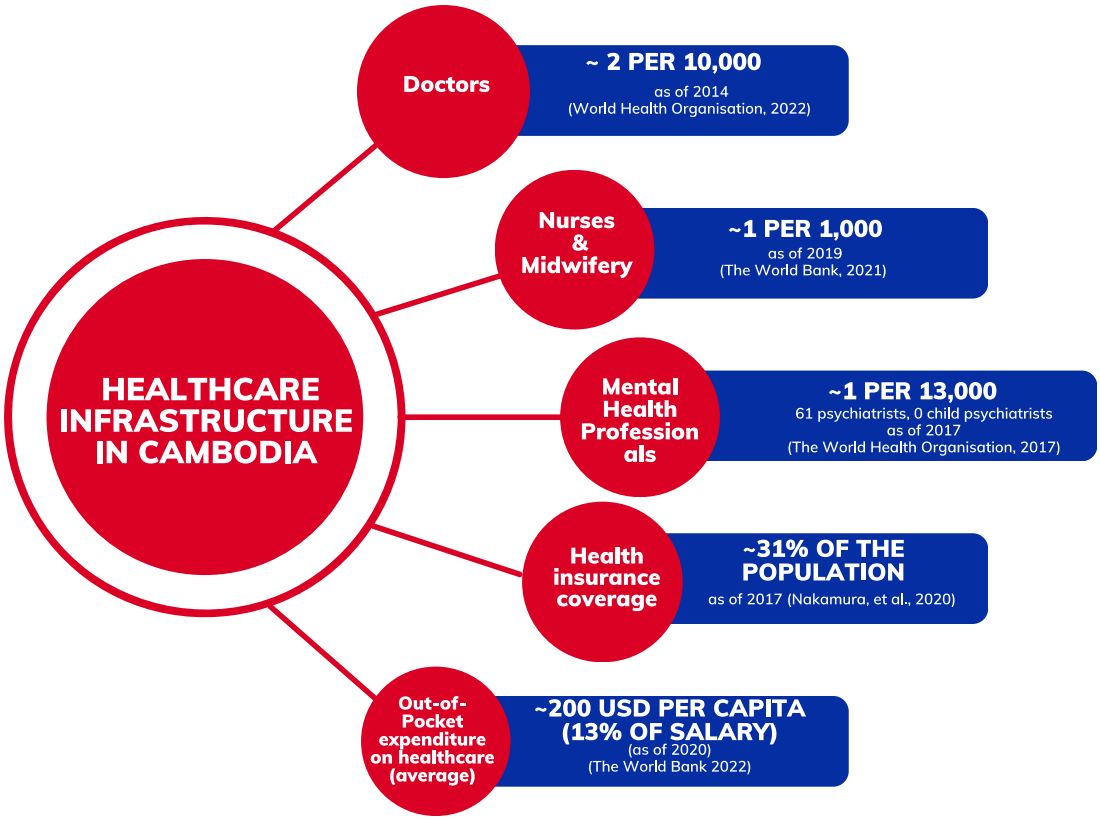
Type	Scope (Population)	Functions
National Hospital (Level 3)	~2,000,000	All surgery and treatment, with some cases requiring patients to travel abroad. Provide training to staff.
Referral Hospital (Level 2)	~80,000-200,000	Similar to the functions of the national hospital with fewer specialist staff and services. Should be no further than a 2-hour drive for populated areas and a 3-hour drive for rural areas.
District Health Centre (Level 1)	8,000-12,000	Operates as a general practice - no surgery. Should be no further than 10km for those in catchment area.
Local Health Centre (Level 1)	2,000-3,000	Operates principally as a referral centre, referring patients to the higher levels of care. Can provide first aid and emergency care.
Provincial and Community-Based Rehabilitation Centres (PRCs) (N/A)	Over 20,000*	Provides orthosis, prosthesis, and assistive devices. Conducts physical rehabilitation. Provide training to staff.

*A MAJORITY OF SERVICES IN PRCS ARE PROVIDED BY THE CENTRES RUN OR SUPPORTED BY NGOS: ICRC, EXCEED, HUMANITY AND INCLUSION (HI)

NATIONAL INSTITUTE OF STATISTICS OF CAMBODIA (2022). AND DATA PROVIDED BY EXCEED WORLDWIDE (2023)

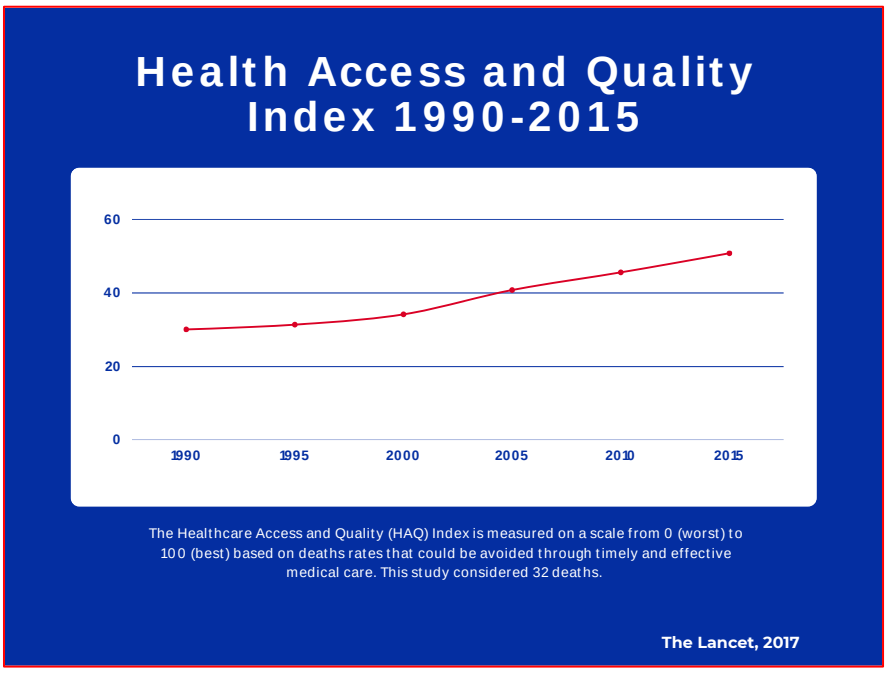
The Cambodian healthcare system is heavily reliant on external support, which has been steadily declining. Some costs are being absorbed by the government, but others are also being pushed onto the service users. Only 15.3% of people in Cambodia use public healthcare facilities, with 84% using private healthcare, and a small minority (less than 1%) using traditional medicine or seek healthcare abroad (The National Institute of Statistics of the Ministry of Planning, 2022, p. 96). The lack of trust in the public healthcare system is reflected in the data on spending on healthcare in Cambodia, with out-of-pocket expenditure accounting for 60% of spending on medical care in the country (World Health Organisation, 2023). Given the links between disability and poverty – especially in low-income, conflict-affected countries such as Cambodia – the number of persons with disabilities using public, rather than private, healthcare centres is likely to be disproportionate when compared to the general population. Providing partial explanation for the limited number of people that choose to use public healthcare, 55% of 87 EO survivors and persons with disabilities interviewed for the Sir Bobby Charlton Foundation study (2022) claimed that they did not trust the quality of medical care in public facilities. In an interview with ASEAN, the Director of Disability at MoSVY, Sann Ratana, supported this finding, stating that people in Cambodia "are afraid of dying, but they're also afraid of doctors". He said that this was a communications issue and that people needed to be better informed of available healthcare services. The surgical director of an NGO-run hospital in Siem Reap claimed that patients have some

basis to believe that public medical care is of poor quality, or at least has been in the past, claiming that patients often come into his hospital for treatment after having received incorrect or low-quality treatment and surgery (for trauma victims) in public facilities, creating more complications than the injury itself.



Regarding the quality and access of care in the country, a study from 1990-2015 found that Cambodia has one of the lowest healthcare quality and access scores in the world, although it is improving (The Lancet, 2017). Considering the transportation and infrastructural barriers for persons with disabilities in Cambodia, the accessibility of healthcare is likely to be far lower for persons with disabilities in comparison to the general population – especially when combined with lower (by comparison) available finances for accommodation and methods of independent transport to support trips to hospitals and healthcare centres, often in provincial capitals or Phnom Penh. A study in 2020 that interviewed 64 survivors found emergency evacuation a responsibility of HMA VA actors, to be limited in Cambodia (The Sir Bobby Charlton Foundation, 2022). In the study, 64% of the survivors that were interviewed relied on personal vehicles (14% using non-motorised modes of transport) to get to hospital: one consequence of the lack of emergency evacuation capability was the extended time it took for survivors to reach hospitals, with almost all respondents stating that it took over two hours following their incident and more than 50% taking over five hours (ibid., 2022). One man who was injured as a child recalled an eight-hour journey in a cow cart, while another man, injured in Ratanakiri in 2019, recalled that the ambulance could only get as close as an hour scooter ride away from the location of his accident (ibid., 2022). Increased prehospital time correlates with the likelihood of morbidity and mortality (See Bedard et al., 2020; Gauss et al., 2019; and Murad et al., 2012). Despite general improvements in the capacity of

Cambodia's healthcare system in the 21st century, the CMAA reported that Cambodia has seen a decrease in available public healthcare services in recent years (Landmine & Cluster Munition Monitor, 2022).



To counter the limitations of prehospital care and emergency evacuation capacities of the RGC, the CMAA reported that the NGO 'The Trauma Care Foundation' provided first aid training to 962 people from village health support groups, local health centres, village leaders, and OPDs. This group of trained personnel provided vital first aid to 1,389 (61%) of 2,271 people who suffered injuries in 2022. In addition, fulfilling their role as the NMAA to support emergency care, the CMAA provided the 41 victims in 2022 with emergency response kits and finances to support emergency care (as well as additional financial support for healthcare costs to 256 previous victims). The training of first aid at the community level by the Trauma Care Foundation is critical – according to one trained paramedic who was interviewed - as the golden hour (the first hour following injury) and the platinum five minutes (the first five minutes after injury) are both fundamental to a patient's outcome so, where rapid emergency care services are not available, people in the local community need to know first aid. CMAC stated that they provide emergency transport in the areas that they operate when it is required.

Emergency care following first aid, emergency transport, and prehospital care also present a challenge in Cambodia, with the main challenge, according to interviews with the CMAA, ICRC and MoH, being a lack of specialist staff, especially outside of Phnom Penh. The other stated issue is the lack of a centralised and digitized database that hospitals can use to retrieve medical records and track patients – the CMAA claim in their Article 7 report for 2022[31] that a lack of data on whether EO victims and persons with disabilities receive services from the MoH as one of their biggest challenges (alongside a lack of data on employment and income) (CMAA, 2023). According to the MoH Deputy Director of Hospital Services, there is also a lack of standardisation across hospitals, even at the provincial level, and there were questions around the effectiveness of the implementation of HSP3 at the subnational level. This lack of standardisation included the cost of care: certain healthcare is supposed to be free to those with disabilities and those with IDPoor, but in some cases, supported by testimonies in the 2022 Sir Bobby Charlton Foundation Study, persons with disabilities pay for services as staff do not offer free services unless they are requested by the user.

[31] Provided directly from the CMAA via email.

In addition to the financial and physical barriers to emergency care, accessible infrastructure, accommodation, and transport increase ongoing healthcare costs of the service user with some EO survivors interviewed in the Sir Bobby Charlton Foundation (2022) study having to regularly travel hundreds of kilometres with their family (often from rural areas to Phnom Penh) costing hundreds of dollars to reach healthcare facilities that provide the required specialist treatment. In addition, the study found that, even when EO victims could afford the care and transport, many stated that they (and/or their family members accompanying them, which is often necessary) could not sacrifice the lost salary due to absence from work with most working in the informal sector in rural areas (ibid., 2022). To note, these same barriers have been highlighted in various reports over the past two decades (See: Thomas, 2005; Bailey & Nguon, 2014). It is estimated that a person with disabilities in Cambodia spends approximately three to four times the amount on healthcare than a person without disabilities (depending on the severity of disability) (Palmer et al., 2019).

Beyond the financial aspect of accessing healthcare, while no EO survivor of persons with disabilities in the Sir Bobby Charlton Foundation study (2022) criticised the accessibility of hospital buildings, 97% of respondents claimed they faced challenges related to transport and public areas. The Phnom Penh Centre For Independent Living, an NGO with the mission to empower people with severe disabilities to live independently, reported in 2021 that public streets and roadways are not suitable for persons with disabilities, and getting around can be dangerous and even impossible, especially for those in rural villages who are often unable to leave their houses and are forced to stay at home and remain in constant need of assistance (The ASEAN Post Team, 2021). Interviews with representatives from the CMAA and MoSVY corroborated this, stating that for those with sensory, physical, and intellectual disabilities there are particular and specific challenges to their access and mobility. When questioned on accessibility, the Deputy Secretary General of the Disability Action Council stated that they recognise that accessibility is one of the core issues for people with disabilities in Cambodia, and, to counter this, if proper funding is received, they are to build 22 accessible community buildings, which could be used as a model for access to supermarkets, hospitals, airports, etc.

It should be noted that accessibility is not limited to those with physical disabilities, but also for those with sensory and intellectual disabilities. As part of their objective to achieve universal healthcare, the MoH considers sensory care in their HSP 2016-2020. According to the WHO (2019), the planning process included projecting the estimated costs of activities and targets within the HSP to inform priority setting and resource mobilisation. According to the WHO, this process also included "defining the resources, or inputs, associated with eye care, estimating the average cost for priority interventions, and projecting the total number of these priority interventions that needed to be provided each year, as well as the costs associated with running the overall programme, including activities such as monitoring and evaluation." (World Health Organisation, 2019, p. 113). This process has enabled the MoH to meet the national targets for eye care which informed the development of the national eye care plan (National Strategic Plan for Blindness Prevention and Control 2016–2020), which includes comprehensive objectives that cover many aspects of strengthening health systems, such as workforce requirements, activities, outputs, time frames, responsible agencies, targets, indicators and associated costs (World Health Organisation, 2019). The impact of these interventions, notably, do not improve the general accessibility of healthcare facilities for persons with sensory disabilities, but does improve the structure of care for them.

4.3.2. Mental Health and Psychosocial Support

The WHO released a study in 2016 claiming that for every $1 invested in mental health services to reduce depression and anxiety yields (on average across low- medium- and high-income countries) a $4 return because of the reduction in healthcare costs and the increase in economic participation (World Health Organisaiton, 2016). Despite the mutual benefit (to both the RGC and service users) and economic rationale of investing in mental health is 0.001% of national budget in Cambodia (Parry, Ean, Sinclair, & Wilkinson, 2020) (far lower than the 3% global average (World Health Organisaiton, 2016)). This emphasises the need for the inclusion of mental health support in an integrated, multi-sector approach, to support EO victims and persons with disabilities.

Two studies, a decade apart, found that many of the dozens of EO victims and survivors experienced stress, PTSD, depression, sadness, anxiety, and difficulty with sleep (Cardozo, Blanton, Tor, & Zalewski, 2012; The Sir Bobby Charlton Foundation, 2022). Like in other mine affected countries, MHPSS is an area with the great need for improvement regarding both service provision and understanding. There has been repeated recognition over the years for the need for improved mental health and psychosocial services for EO survivors[32], which was reflected in the interviews with rehabilitation and health experts, quoting the compounding effect of violent trauma combined with the mental health impact of living with a disability in Cambodia.

According to an interview with the surgical director of an NGO-run hospital in Siem Reap, the primary need of EO victims in Cambodia, in addition to medical services and social protection, is mental healthcare, which unlike social protection, health and rehabilitation, is not a core focus of national strategy. In fact, every organisation and government ministry that participated in interviews labelled mental health as a principal need of EO victims and persons with disabilities, and mental health services as a vital barrier to an effective VA system in the country.

Compounding the impact of its weak mental health system, Cambodia has one of the highest country rates of persons with intellectual disabilities, which account for 1.41% of the population (Institute for Health Metrics and Evaluation, Global Burden of Disease (2019)). In more detail, a cross-sectional study showed rates of depression at 16.7%, anxiety at 27.4%, and post-traumatic stress disorder at 7.6% (Seponski, Lahar, Khann, Kao, & Schunert, 2018), while previous studies have shown the rate of depression ranging from 12% to 18%, the rate of anxiety as high as 53%, and PTSD from 7% to 86% (Schunert, et al., 2012; Seponski et al., 2018; Dubois, et al., 2004; Stammel, et al., 2013; Sonis, et al., 2009; Jegannathan, et al., 2015). The rate of suicide has been recorded at 13-44 per 100,000 (Schunert, et al., 2012; Olofsson, San Sebastian, & Jegannathan, 2018; Sakisakai, Fujitai et al., 2018), and the misuse disorders have been estimated at over 2% (Devaney, Reid, & Baldwin, 2007)[33]. According to the SBC Foundation study (2022) 47% of the 80 survivors and persons with disabilities interviewed across six provinces claimed they desired some form of mental health support, with only one respondent claiming that they had been offered a form of mental health counselling. In the same study, 33% of respondents claimed to participate in peer-peer support mechanisms, of which all found that this improved their quality of life (The Sir Bobby Charlton Foundation, 2022).

[32] See: Somasundaram & Renol, 1998; Somasundaram, van de Put, Eisenbruch, & de Jong, 1999; Somasundaram & Renol, 2007; Thapa, 2011; Cardozo, Blanton, Tor, & Zalewski, 2012; UNPRPD, 2021; The Sir Bobby Charlton Foundation, 2022)
[33] For more information on the context of mental health, see (Parry, Ean, Sinclair, & Wilkinson, 2020)

MHPSS activities, including peer-to-peer support, help EO survivors and indirect victims manage stress, trauma and repeat trauma, and improve the outcome of rehabilitation and medical treatment. To achieve this, there is a need for mental health services to be integrated, like rehabilitation, into the healthcare nexus for EO victims to ensure that they can fully recover, physically and mentally, from an incident of harm (Jegannathan, Kullgren, & Deva, 2015). This is also true for social protection and assistance. Mental health support is influenced by and influences socioeconomic inclusion – if persons with disabilities are not able to have meaningful economic and social participation, this is likely to have a negative impact on their mental health. Mental health issues can present barriers to meaningful social and economic participation: a study in Siem Reap (2012) found that a lack of income-generating activities was linked with risks of higher levels of depression and found that the unemployment rate among EO victims was 15% higher than the general unemployment rate in Siem Reap, but they were unable to distinguish whether this was related to mental health, due to the barriers to employment also linked to disability (ibid., 2012). Contextualising the need for integrated mental health strategy in Cambodia, the executive director of a local NGO (DDSP) stated that people in Cambodia who are isolated because of their disability face depression. A mental healthcare policy advisor to the RGC stated that muted personal wealth and health were two of the fundamental sources of mental health issues in Cambodia, stating that (to emphasise the point) if you do not have food on the table, a roof over your head, and a prosthesis to allow you to walk then you can develop depression - without addressing the sources of that depression, no standard of mental health support will help. This was also, he claimed, true for the anxiety caused by the risk of EO harm to oneself or friends – if the EO are still there, the anxiety will remain.

A study in 2019 reported that, despite the growth of the mental healthcare system and the introduction of the National Mental Health and Substance Misuse Strategic Plan 2011–2015, there were only approximately 60 psychiatrists in Cambodia in 2017, or one for every 260,000 people (Parry & Wilkinson, 2019). This makes Cambodia, although comparable to its neighbours Myanmar and Indonesia, one of the weakest mental health infrastructures in the world. During interviews, the MoH reported that they only had ten psychiatrists in their system, all located at provincial hospitals or in Phnom Penh. HSP3 notes that the need for mental health support is high, but the health system is still ill-equipped to deal with the demand and community programs to manage the conditions are limited.

There has been significant effort to describe Cambodian culture-bound syndromes and idioms of distress, particularly relating to trauma in both adults and children, examples include "baksbat" (broken courage) "kut chraen" (thinking too much), "mour mao" (easily angered) in children and "khyal" (wind like substance) attacks (in Cambodian refugees) (Somasundaram et al., 1999; Figge et al., 2020; Chimm, 2013; Hinton et al., 2016; Hinton et al., 2010). The importance of contextualised mental health research has been highlighted as crucial to developing accurate diagnostic criteria, effective interventions, and appropriate long-term follow up (Figge et al., 2022; Hinton, Alexander, Eng, & Choung, 2012; Kidron & Laurence, 2019; Chimm, 2013; Agger, 2015). The importance of culturally appropriate MHPSS was reflected in an interview with a representative of the Jesuit Refugee Service, an NGO with a long history in Cambodia that has a centre in Siem Reap that contains a garden of reflection open to persons with disabilities, who highlighted that mental health support needs to be contextualised to account for the belief in Karma related to Buddhism (prevalent among approximately 93% of the population (US Embassy in Cambodia, 2022)). According to an interviewed mental health consultant to the RGC, MHPSS needs to be contextualised, and done in cooperating with village chiefs, monks, traditional

healers, and other important members of the community – "There is a need to understand spirituality of Buddhism in order to provide effective care. If one is feeling depressed, they'll seek out the mechanisms they know, not NGOs."

A study in 2020 conducted a thematic analysis of interviews with 18 people who had been working in the mental health sector in Cambodia for at least several years. Focusing on barriers and opportunities for mental healthcare in Cambodia, they found that there had been significant development in mental health services in Cambodia (education, training, resources), but there was a need to create a national mental health legislation and strategic plan to form a structured approach to obtaining universal healthcare (Parry et al., 2020). Recognising the importance of mental health, The Director of Preventative Medicine and the Deputy Director of Hospital Services at the MoH claimed that the MoH Department of Mental Health and Substance Abuse has formed a working group that is looking to develop a new National Mental Health Strategic Plan, but it is waiting for approval. The senior representatives from the MoH agreed that mental health is one of the most important considerations when supporting persons with disabilities, and that each one of the provincial hospitals has a mental health focal person. According to the UNDP, NGOs sometimes refer people to these hospitals for mental health support. According to HSP3, in 2016 psychiatric services and primary mental health services were available in 73 Referral Hospitals and 194 Healthcare Centres (Royal Government of Cambodia, 2016).

The participants to the Parry (2020) thematic study also commented on a need to raise awareness about mental health, strengthen collaborations between mental health stakeholders, develop a mental health model contextualised to Cambodia, a vast increase in capacity (funding and resources), and an improvement in the quality of mental health staff and standards (Parry, Ean, Sinclair, & Wilkinson, 2020)[34]. MoSVY has social workers who could support the provision of mental health services, but a system to coordinate activities would be needed.

The CMAA, in their Article 7 report of activities, presented that, in 2022 1,706 survivors and persons with disabilities participated in peer-to-peer counselling, and 80 medical students and 80 members of the volunteer survival network and staff from PRCs received psychosocial support training (CMAA, 2023). The CMAA also helped 33 women with disabilities attend sporting events. In an interview, representatives from the ICRC referred to their world-champion wheelchair basketball team that operates out of the Battambang physical rehabilitation centre, claiming that this psychosocial initiative is extremely beneficial on the mental health of persons with disabilities, including EO victims.

4.3.3. Physical Rehabilitation Services

In Cambodia, physical rehabilitation services are principally provided out of the PRCs stated in the previous section. The PwDF manages physical rehabilitation in Cambodia with the support of three NGOs. The centres, in accordance with the Oslo Action Plan and IMAS 13.10. provide prostheses, orthoses, and other assistive devices as well as physiotherapy across 11 PRCs: Phnom Penh, Kien

[34] It is highly recommended that anyone interested in mental healthcare in Cambodia reads this report as studies that address the development of mental health in Cambodia are scarce.

Khleang (Phnom Penh); Battambang; Kampong Cham; Kampong Chhnang; Kampong Speu; Preah Sihanouk; Prey Veng; Siem Reap; Kratie; and Takeo. The ICRC provides financial and technical support to the PRCs in Battambang and Kampong Speu, while EXCEED Worldwide supports two PRCs in Kampong Som and Kampong Chhnang, and HI funds and provides administrative support to the PRC in Kampong Cham. In 2022, the Korea International Cooperation Agency (KOICA) provided equipment to the Battambang Physical Rehabilitation Centre in cooperation with CMAA and the PwDF and ACCESS provided training on physical accessibility as well as emergency items (The Landmine & Cluster Munition Monitor). Also currently under the responsibilities of MoSVY are three repair centres in Preah Vihear, Kompong Tham and Svey Rieng, an orthopaedic components factory, a prosthetic orthotics training school, and a Spinal Cord Injury Rehabilitation Centre in Battambang. To note, Veterans International Cambodia (VIC) supported three centres in Kien Khleang, Kratie, and Prey Veng, and conducted community-based rehabilitation in Phnom Penh, Kandal, Kratie, Prey Veng, and Svay Rieng provinces until early 2023, when they handed over responsibility to PwDF.

According to the CMAA, 23,468 persons with disabilities, including 8,630 mine/ERW survivors, benefitted from the services provided in the 11 PRCs, including the provision of prostheses, orthoses, wheelchairs, tricycles, and walking aids (including crutches and walking frames). According to the CMAA's figures, as a collective, the PRCs produced and repaired 23,759 products: 3,496 prosthetics (3,343 lower limbs, 153 upper limbs), 2,537 orthotics (2,422 lower limbs, 76 upper limbs and 39 spinals), 41 seating systems, 1,033 wheelchairs (979 for adult and 54 for child), 41 tricycles, 775 non-orthopaedic procedures, 3,887 walking aids, and conducted 11,969 repairs. In addition, they recorded that 23,367 people received physiotherapy (ibid., 2023) from community-based rehabilitation services – available across all 25 provinces – provided thousands of persons with disabilities with services: 5,247 persons with disabilities were received from mobile repaired services, and 2,522 persons with disabilities had assessment and evaluation. The Spinal Cord Injury Rehabilitation Centre in Battambang, the three repair centres, and the orthopaedic components factory are also to be transferred over to the MoH.

MoSVY and the PwDF have occupied government responsibility for physical rehabilitation services in Cambodia since 1989, but, due to the growing recognition of the need for rehabilitation to be linked to healthcare services, there is a widespread consensus among the primary physical rehabilitation stakeholders that were interviewed (including EXCEED Worldwide, HI and the ICRC) that rehabilitation would be better supported and managed under the MoH. On 17th October 2022, the Council of Ministers, following a decision of Prime Minister Hun Sen, declared that the services currently conducted in the PRCs will be transferred over to the MoH. This process is ongoing as negotiations between the two ministries and other stakeholders continue. It the hope of the rehabilitation community campaigning for the transfer that this shift will improve the referral system and synergy between medical services, reduce issues with staff retention, and increase the level of capacity and financial support for rehabilitation services.

Building on the data collected by the CMAA, the Khmer Association of Prosthetists Orthotists[35] conducted a survey to provide the latest information on Cambodia's PRCs and associated services in order to assist the transition of responsibility for rehabilitation services from MoSVY to the MoH[36]. The

[35] In cooperation with Exceed Worldwide, the Department of Prosthetics Orthotics, and the National Institute of Social Affairs
[36] This information is not published publicly – to collect the data managers of each PRC and Repair Centres were emailed. The response to these emails was 100% across the 11 PRCs and three repair centres.

results of the survey showed that, between January 1st and November 30th, 2022, approximately 74,000 persons with disabilities benefitted from rehabilitation services. 29 Prosthetist Orthotists (POs) (24 working in NGO-supported centres) and 57 Prosthetist Orthotists Technicians (POTs) (30 working in NGO-run centres) produced and repaired 13,403 devices. In addition, in the 11 months, the POs and POTs delivered and repaired 2,284 wheelchairs, and delivered 3,524 canes, crutches, and walkers. In addition to this, the survey found that 49,420 physiotherapy sessions were held. Beyond the centres, the PRCs supported by NGOs contacted and offered services to 6,758 clients (90% of which were done by ICRC- and HI-supported centres). It should be noted that across all the services, the NGO-supported centres provided a large majority of services, with the ICRC-centres providing approximately half.

In addition to collecting data, the Khmer Association of Prosthetists Orthotists survey asked about concerns within the PRCs – 91% of respondents had concerns about staffing, with 100% wanting additional staff, and 90% expressed concerns about supply chains and materials. Regarding staff concerns, of the 37 that have graduated from the Prosthetic Orthotic school since 2013, 15 had left the profession and two had moved into admin roles. Reflecting this, one of the most pressing issues highlighted in interviews with MoSVY, the CMAA, ICRC, EXCEED Worldwide, and other stakeholders interviewed for this report was staff recruitment and retention, and documents on rehabilitation over the past ten years have also stressed this growing problem (Bailey & Nguon, 2014). Recruitment and retention of staff in PRCs has been an issue since rehabilitation services transferred over from NGOs to the PwDF. There are complaints among staff that the incentive to continue working in the centres is low due to the reduction of pay and lack of benefits such as pensions (SBC Foundation, 2022). This has also led to a low intake of new staff, according to the ICRC and EXCEED Worldwide, resulting in an aging population of technicians that are soon to retire, damaging the human resource capacity of the centres. The Deputy Secretary General of the DAC claimed that there has been a reduction in quality in the government-run PRCs due to the limited human resources. According to data provided by the Khmer Association of Prosthetists Orthotists survey, 77% of services were provided in the EXCEED Worldwide- and ICRC-supported centres in 2022 (January – November) with, according to EXCEED Worldwide and the ICRC, the capacity of the PwDF-run centres reducing year after year. In addition, some of the workshops and referral centres are being moved from urban to rural areas, according to the ICRC, making them less accessible to aging staff who are looking to retire. Moving rehabilitation sites to rural areas also makes them less accessible to persons with disabilities.

The PRC stakeholders expressed in interviews that there needs to be more investment in graduates to improve recruitment and retention. Other concerns relating to the financial sustainability of the PRCs and the free services they offer will need to be addressed in the new strategy for rehabilitation under the MoH, along safeguarding measures to ensure data and referral mechanisms of existing clients are not lost. If done correctly, the resulting system could be more sustainable, and with better referral between services for EO victims and persons with disabilities, taking a step towards the desire for universal health coverage under the CSDGs.

Part of the mandate of ACCESS is to improve the sustainability and effectiveness of Cambodian PRCs run by the PwDF but interviewed stakeholders from NGOs supporting PRCs claimed that ACCESS has failed to achieve this goal. A DFAT-funded third-party review of the ACCESS programme states that ACCESS was effective in improving the coverage and quality of services, but limited in terms of

inclusiveness (Urbano et al., 2023). Specifically related to the PRCs, the improvement in quality standards has been undermined by a lack of a workforce (ibid., 2023).

Another issue is, according to an interview with one international monitoring body, that awareness of government services is limited in among the general population. Anecdotal evidence from two separate interviews suggests that the centre in Kampong Thom only services five people per week, despite having a full-time POT, a full-time physiotherapist, and a centre manager. The surgical director of an NGO-run hospital in Siem Reap reinforced this point, stating that one of the main issues for people requiring rehabilitation is that "most of them don't know where to go", and that even "doctors don't know where [PRCs are]". HI offered another explanation for limited attendance of those needing rehabilitation services. They stated that their outreach programme must convince people to come to the centre to receive services as people complain that they cannot afford to lose income through the time away from work. The executive director of one community-based rehabilitation programme DDSP claimed that low access rates of services was a combination of the two – limited knowledge on available services, combined with a lack of financial resources to access services (specifically referencing time out of work transport, time out of work). The ICRC and EXCEED Worldwide support auxiliary costs such as transport, as does the PwDF but less so, and even some clearance organisations such as APOPO (in collaboration with HI) assist with transport and food for EO victims accessing rehabilitation, who, according to APPOPO's director, would not have otherwise been able to afford it (10 per month).

It should also be noted that the provision of wheelchairs was mentioned by MoSVY, the CMAA, PwDF, the DAC, and three NGO organisations as the limitations of RGC-managed rehabilitation services in the country, with only ten allocated to distribution by the PwDF per month. Additionally the quality of government services had been questioned by five separate NGO directors, and, collectively, they had anecdotal evidence of poor services from dozens of persons with disabilities. The Director of the PwDF, talking on this point in an interview, claimed that they did not have the 'money in the system' to provide services as comprehensively as centres supported NGOs, and are looking at developing new strategies with the MoEF.

As well as the services provided in the PRCs, community-based rehabilitation services are also available, with some mobile/outreach/remote services provided out of the PRCs (such as the one managed by HI), although, according to interviews with EXCEED Worldwide and the ICRC, the ability to provide mobile services has reduced since the pandemic. That being said, NGOs such as the DDSP and the Jesuit Refugee Service (JRS) provide physical rehabilitation services and distribute wheelchairs to communities respectively. The Spinal Cord Injury Centre in Battambang also provides home-based care in six districts for patients who have been discharged from the centre and raises awareness with local authorities on the rights and needs of people with spinal cord injury (UNPRPD, 2021). According to respondents in the Sir Bobby Charlton Foundation study (2022), both staff and EO survivors commented on the need for increased community-based services, with the ICRC-supported centre in Battambang claiming that they had cut back on services, and the EXCEED Worldwide-supported centre in Kampong Chhnang claiming that they could not afford to provide the service at all. According to the same 70% of EO survivors granted financial support for transport and other auxiliary costs, but almost all respondents stated that they had incurred some costs towards food, accommodation, or transport (The Sir Bobby Charlton Foundation, 2022).

It was the general consensus among both government and non-government interviewees that rehabilitation is still largely reliant on international organisations and donor funding, and that the current system is understaffed and underfunded. The result of this, according to stakeholders, is that the resources – particularly staff – are impeding the ability of the PRCs to provide rehabilitation services in terms of quality, quantity, and scope. This issue, according to stakeholders, will continue to worsen unless there is a significant change to the system, with almost all interviewed stakeholders claiming that the transition to the MoH provides an opportunity for improvement. Although not many analyses have been conducted on the cost-benefit of a prosthesis and rehabilitation on quality of life (Donnelley, et al., 2021), there is an abundance of anecdotal evidence to exemplify the importance of these services for EO victims and persons with disabilities regarding their ability to have meaningful participation in society – see EXCEED Worldwide, HI, and ICRC websites for testimonies.

4.3.4. Socioeconomic Inclusion and Social Protection

Financial Support

At the 11th Workability Asia Conference 2018, hosted by Workability Asia, Essential Personnel Cambodia, and the DAC, the Essential Personnel Cambodia executive director Ouch Nimul stated that "Most disabled people are the poorest of the poor, with women and children, in particular, remaining the most vulnerable, and that their economic activities stay low."…"their access to social services, such as health, education, skills training and jobs remains limited" (Chakrya, 2018).

Despite the reduction in EO harm, the growth of the economy, and the declining poverty rate (World Bank, 2022), Cambodia remains one of the poorest and most undeveloped countries in Southeast Asia, with USD4,192 GDP per capita (National Institute of Statistics and Ministry of Planning, 2021). Large disparities in living standards are also prevalent, especially between rural and urban areas (National Institute of Statistics and Ministry of Planning, 2021). One of the most adversely affected groups in Cambodia – as in other countries – are people with disabilities (Palmer, et al., 2019). Research suggests that people with disabilities are more likely to overpopulate the poor due to economic disadvantage, restricted access to education, and fewer employment opportunities (see Filmer, 2008; Grech, 2016; Mitra, 2018; Mitra et al., 2013). In Yoshito Takasaki's paper (2020) he emphasised the specific link between landmine amputees and poverty, stating that adults who had undergone limb amputation as a result of contact from landmines have reduced consumption and income, increased poverty (especially amongst the poorest of the poor) and reduced subjective well-being (Takashi, 2020). In his paper, he claims that, following landmine incident and amputation, there is a cycle of low labour productivity, low earnings and low accumulation of productive assets and social capital - which leads to adverse intergenerational effects on child schooling and labour (ibid., 2020). In addition, the cost of living for people with disabilities is likely to be higher than for people without disabilities due to medical expenses, specialised transportation, and dietary requirements (Sen, 2004), with a paper by Palmer, Williams and McPake (2019) claiming that direct cost of disability doubles the poverty rate in Cambodian households with disabled members from 18% to 37% and increases the poverty gap from 3% to 8%. They go on to say that only 7% of the costs are met through family sources and government support (Palmer et al., 2019). Adding to this, Gartrell stated in her 2010 paper that disabled people in Cambodia experience systematic marginalization in the labour market and suggests that disabled people are more likely than

able-bodied people to be unemployed, in low status occupations, earn less or be out of the labour market (Gartrell, 2009). A study by Sann et al., (2013) that focused on the implications of long-term disability caused by road accidents also found that a lack of access to services for people with disability increased the risk of poverty.

The main framework for socioeconomic support at the national level over the past years has been the SPPF, which covers two pillars of socioeconomic support: social assistance and social security. Social security relates to various insurances (health, employment injury, disability, unemployment) and pensions. Social assistance provides support to those who live near the poverty line as well as persons with disability. Social assistance includes emergency response, human capital development, vocational training, and welfare for vulnerable people. Social support that has been reported to reach an unspecified number of EO victims includes: the HEF to provide free health care to families holding IDPoor cards, support for schooling (scholarships and food), and vocational training. The reach of these programmes, however, is limited. For instance, the method by which people are identified[37] and classified for IDPoor – which also grants them a monthly income of around 50usd per month (depending on the recipient's circumstance) - has been criticised as it is based on variables that may not influence the victim's ability to support themselves or their family: if they have a concrete house, moto-bike, or livestock, they are not eligible to benefit from the IDPoor scheme. Applying for these passes requires the person to have a form of identification (birth certificate or family card), but many people do not have this – especially in rural areas – and will need to spend significant time navigating the bureaucratic process to successfully apply. Additionally, due to the lack of knowledge of EO victims and persons with disabilities on this discretionary process, the support for some recipients is removed without explanation for that loss of support.

The National Social Security Fund (NSSF) provides social protection (health insurance, injury insurance, maternal and sickness cover) people – including survivors and people with disabilities - working in large (since 2007) and small-to-medium (since 2018) enterprises. This only includes formal sector workers, which accounts for less than 20% of the population (United Nations, 2021). With over 4.1 million eligible workers, the NSSF has reportedly provided support to over 1.4 million people (International Labour Office, 2021). In addition, launched in 2022, the NSSF also began to pay a Disability Pension: A biweekly payment to insured persons who have at least five years of contributions and are no longer able to work because of a disability, with a minimum payment of 45 percent of the insured person's average monthly covered earnings (United States Social Security Administration, 2022). The Survivor Pension was also introduced in which a biweekly payment is made to the eligible dependents of a deceased person who was receiving old-age or disability pension or had at least 5 years of contributions. They receive 45% of the old-age or disability pension that the deceased was entitled to receive (ibid., 2022). The RGC included consideration for social protection in its 'Rectangular Strategy for Growth, Employment, Equity and Efficiency Phase Four', which serves as the policy framework for the NSDP 2019-2023. In the document, the RGC stated a commitment to implement a "food reserve program, school feeding program, scholarship program, cash support to pregnant women and children of the poor families which are part of social assistance system; and has put in place health equity fund, national social security on healthcare and occupational risks for workers-employees under the labour law,

[37] For a full description on the procedures for identifying 'Poor Households', please refer to the following report by the Ministry of Planning (2017): https://mop.idpoor.gov.kh/files/documents/IDPoor_Procedures_Urban.pdf

healthcare insurance scheme for civil servants, retirees and veterans, and PwDF." (Royal Government of Cambodia, 2018, p. 26).

To note, MoSVY builds between five and ten houses for persons with disabilities each year, according to their Director of Disability Welfare Department.

A cross-cutting issue that impacts the inclusivity of EO victims and persons with disabilities in the above schemes, according to representatives from both government and non-government institutions, is a poor identification and data management mechanisms especially in regard to persons with sensory and intellectual disabilities. IDPoor and associate schemes such as the Disability Allowance (USD5 per month for persons with disabilities in household receiving IDPoor benefit) rely on village leaders or local authorities to identify persons eligible for the schemes, but these subnational actors, according to local NGO DDSP executive, often do not have the knowledge or skills to identify all forms of disability.

The CMAA collect data on casualties in their Cambodian information victim information system (CMVIS) that tracks casualties using data form various actors, including clearance operators - the two non-government mine clearance organisations interviewed (APOPO and MAG) claimed to be collecting data and disseminating it to the CMAA for CMVIS. Both organisations claimed that some clearance organisations are more detailed than others in the data that they collect. The QLS being rolled out by the CMAA and MoSVY, and the DWDP Management Information System (MIS) for identification of persons with disability will build on CMVIS, collecting more detailed information on a wider scope of people, and will be a useful tools to improve the reach of social assistance mechanisms and better target recipients.

In addition to the QLS, according to Sann Ratana (director of the DWDP), as of 2023, over 250,000 persons with disabilities have been also identified and logged in MoSVY's information system, but only a minority have received 'Persons with Disabilities ID Card'. The new ID Card grants persons with disabilities access various benefits, depending on their kind of disability, including social assistance packages, health services, educational services, and emergency intervention in case of a natural disaster. There has also been the roll out of the Disability Identification App by MoSVY, in cooperation with ACCESS, which has only been downloaded around 5,000 times[38] - there are concerns that the elderly, those who are unable to afford smart phones, and those living in rural areas will go undetected by the app. The registration, along with the information management system also helps target specific job opportunities for disabled persons (ibid., 2023). Having identification cards will also help to build awareness of the understanding of disability in the country – along with the revision of the disability law. According to an interview with Sann Ratana, Director of Disability Welfare Department in MoSVY, the programme, which began in 2020 and has identified 250,000 people as persons with disability using the Washington group questions, MoSVY also has a Facebook page where they disseminate information on disabilities, with posts reaching up to one million people.

There is a lack of consistency in the definitions used by various ministries and surveys in relation to disability. In the 2008 census, for instance, the National Institute of Statistics (2009) recorded 192,538 people with disabilities in Cambodia, which constituted 1.44% of the country's population. The National

[38] https://play.google.com/store/apps/details?id=com.application.mosvy.disability&hl=en_GB&gl=US – the app is not available on Apple products.

Institute of Statistics survey in 2014, however, used the Washington Group Disability Questionnaire to estimate that the level of disability is closer to 10% of the population (National Institute of Statistics of Cambodia and Ministry of Planning, 2016). It is important to also note that the QLS uses the Washington Group Questions.

Because of the COVID-19 pandemic, many people lost access to income-generating activities, including EO victims and persons with disabilities. To mitigate this impact, the RGC implemented the Cambodia's Cash Transfer Programme in June 2020 with the support of technical advice from the international community (e.g. Save the Children, UNDP, UNICEF), and awareness raising efforts by OPDs, NGOs and other stakeholders. The programme was budgeted at USD25 millions and targeted to households with IDPoor. According to an assessment by the Asian Development Bank (2022), the Cash Transfer programme succeeded in restoring IDPoor Household spending to 87% of pre-pandemic levels, and people generally received the correct amount of money on time.

Cash transfers have become an institutionalised approach to achieving systematic social protection among the poor, including persons with disabilities, and, although the COVID-19 pandemic is 'over', its impact, like landmine/ERW contamination, casts a shadow over the most vulnerable in Cambodia. Using COVID-19 as a catalyst for progress, and to combat the current consumption poverty rate of 17.8% (World Bank, 2022), and in line with the NSDP, the National Social Policy Protection Framework, and the Rectangular Strategy's commitment to social protection for all, have led to the introduction of the 'Family Package'. The Family Package intends to integrate all existing and planned social assistance benefits (i.e. Cash Transfer Programme for Pregnant Women and Children under Two, Cash Transfer for Children from Poor, Households in Primary and Secondary Schools, Cash Transfer for Persons with Disabilities, and the planned Cash Transfer for Elderly People), and will introduce a Cash Transfer for Persons Living with HIV/AIDS (Narith et al., 2023). The objective of the family package is to support the poor and vulnerable families across the country and protect them from poverty, as well as accelerate human capital accumulation and promote inclusive growth (ibid., 2023).

The Family Package aims to achieve the inclusion of the provision of comprehensive and adequate social assistance covering families and children throughout the life cycle, the improvement of the accessibility and coverage of social assistance benefits for populations in need, the strengthening of the institutional framework for social assistance delivery, the establishment of shared systems/functions to improve the operational efficiency of social assistance benefits, and strengthening of linkages with complementary programmes, social care services and social security (Narith et al., 2023). The family package will be managed by the National Social Assistance Fund, under the guardianship of MoSVY and the MoEF, which will target those for assistance using the IDPoor database with streamlined identification rules, targeting, and identification process. The new system will also digitize payments where possible, reducing administration costs and improving accessibility to service users.

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In addition to the support of the government NGOs and OPDs supply income-generating resources. OPDs throughout Cambodia oversee communal agricultural or livestock schemes in which they collectively grow products to share and sell. The more successful of these community-based schemes can grant loans to members of their community or supply additional seed and/or resources to help farmers in the group increase their yield. According to interviews with the ICRC, as well as supporting vocational training, the organisation provides resources to EO victims and persons with disabilities to

set up or expand businesses, while the Cambodian Red Cross (CRC) has a 0% interest loan scheme to the same effect, which supported 543 EO survivors in 2022. According to the ICRC, the CRC, and the OPDs who have been involved in schemes to loan finance or resources to EO victims and persons with disabilities have been largely successful, but no data was provided. To support this work, according to the CMAA (2023), the government provided financial support in the form of small grants to facilitate the formation of such self-help groups, totalling support for 518 groups.

Education

Data from the United Nations Educational, Scientific and Cultural Organization Institute for Statistics 2018 on educational disparities linked to disability 73% of 14- to 16-year-olds in Cambodia without disability have completed primary education, compared to only 44% peers with a disability, and the out-of-school rate of disabled and non-disabled children was 57% and 7% respectively (ibid., 2021).

Education, for both adults and children, is critical for the prospect of socioeconomic inclusion of EO victims and persons with disabilities. According to Dr. Hang Chuong Naron, Minister of the MoEYS, outlined in Cambodia's Education Strategic Plan 2019-2023, the MoEYS has two key priorities: ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; and ensure effective leadership and management of education officials at all levels (Royal Government of Cambodia, 2019). Although it doesn't reference landmine and ERWs directly, the report lays out activities to create inclusive education, including technical education and vocational training, including training for teachers and scholarships for children with disabilities (ibid, 2019). The plan also includes strategies to develop and promote sport for persons with disabilities (ibid, 2019). In its Rectangular Strategy Phase Four document, synergising with the RGC's commitment to support persons with disabilities in other national documents, the Royal Government of Cambodia committed to "continuing to invest in the construction of primary schools at village level and the secondary schools at commune level based on actual socioeconomic situation; continuing to provide scholarships and essential support to the poor students, students in difficult areas and students with disabilities" (Royal Government of Cambodia, 2018, p. 21).

To address the concerning figures on education for persons with disabilities, MoEYS, with the support of UNICEF, is delivering training on inclusive education for teachers in preschools and primary schools and is developing digital education capacity that will allow students to access education remotely (UNICEF, 2023). In the years 2021-2022, The Ministry has implemented its Inclusive Education Programme in kindergartens where 563 children with disabilities were enrolled, and in community kindergartens where 233 children with disabilities were enrolled. They implemented the same programmes at secondary schools, benefitting 14,420 students with disabilities (Ministry of Education, Youth and Sport, 2023). They also have hundreds of members of staff in inclusive education, provided over USD500,000 to support costs (food, accommodation, transport) of accessing education to 1,059 children with sensory and intellectual disabilities, trained hundreds of members of staff in inclusive education methods, adapted dozens of classrooms for accessibility of persons with disabilities (ibid., 2023).[39]

[39] See the document for more detail: http://moeys.gov.kh/en/media-center/education-congress/education-congress-the-education-youth-and-sport-performance-in-the-academic-year-2021-202-and-goals-for-the-academic-year-2022-20232-2/

Beyond inclusive education, an evaluation report of UNICEF's activities claims that, through their collaboration with the MoEYS, 748 children were enrolled in six special education schools in 2021, and, since 2019, 60 teachers have graduated from the special diploma course on teaching for students with visual and hearing difficulties and have been deployed to schools (Kacapor-Dzihic, Garcia, & Gnim, 2022). In addition, the MoEYS aims to improve sanitation facilities in schools with at least one toilet accessible for people with limited mobility (UNPRPD, 2021).

In addition to the UN and MoEYS, funded by the Government of the Czech Republic, the NGO 'People in Need' and the 'Agile Development Group'[40] began a project in 2022 to contribute to increased employment opportunities for people with disabilities in Phnom Penh, aligned with SDG4 (Quality Education) (People in Need, 2022). They state that the project will promote inclusive education by providing technical support on the development of guidelines for inclusive education, provide training for persons with disabilities, and provide up-to-date equipment to ensure the training program is accessible – according to People in Need there will be support for business incubation program and entrepreneurship (ibid., 2022).

Regarding the role of the CMAA, according to their Article 7 Report to the APMBC for activities conducted in 2022, they helped 361 children with disabilities, including mine/ERW survivors to access primary school, and 53 access public school. They also helped 156 persons with disabilities, including 50 mine/ERW survivors, access vocational training centres – interviewing and referring 493 to other vocational training service providers - and 34 persons with disabilities were receiving training on the how to create a small business from PRC (CMAA, 2023).

Barriers to education still remain for persons with disabilities according to parents and education stakeholders, including a limited capacity of teachers to teach inclusive education, the lack of aids and materials, lack of proper transportation, physical access barriers, lack of time to study or attend school - as children with disabilities need to help with work around the house - and discrimination (The Sir Bobby Charlton Foundation, 2022; UNPRPD, 2021). Highlighted in interviews, there has also been a reduction in the capacity of technical and vocational training centres, with some, such as the one in Banteay Prieb that, according to a representative from the JRS, used to train over 100 persons with disabilities per year being shut down. As pointed out by a consultant working with the government to establish standards on VA, these specialist training centres need to be reimagined as centres for all, inclusive of persons with disabilities, rather than centres for exclusively for persons with disabilities to avoid feelings of discrimination. According to various stakeholders, as vocational training programmes are re-established (after closing due to COVID-19), they are being designed as inclusive.

Employment and Income-Generating Activities

Following education, people with disabilities should have equal access to employment and income-generating opportunities in accordance CRPD. Reflecting this, under Goal 2, Objective 2 of the National

[40] "Agile is a disability innovation & entrepreneurship organisation. Our mission is to create impactful and innovative enterprises, that also create solutions and economic opportunities for PWDs to increase their inclusion, freedom and independence" https://www.l3harris.com/agile-development-group

Employment Policy 2015-2025 – to improved quality and access to education and technical and vocational training (in compliance with national and international standards) – Measure 5 is to increase education and training for disadvantaged groups, including persons with disabilities (Royal Government of Cambodia, 2015). In addition, Article 33 of the Disability Law states that persons with disabilities who have the required qualifications and competence to carry out the duties, role and responsibilities of a particular position have the right to be employed without discrimination (Royal Government of Cambodia, 2009). The Strategic Objective 1 of the NDSP2 bolsters these documents in Goal 1.1. and 1.2., which aim, respectively, to reduce poverty through the promotion of decent work growth, and to strengthen professional and career expansion in order to increase decent livelihood (Royal Government of Cambodia, 2019).

Adding quantitative indicators to these commitments, the Employment Quota for Persons with Disabilities requires that the staff of public entities must include more than 2% persons with disabilities, with the same requirements at 1% for the private sector. Non-compliance to this quota results in a fine of 50% of the salary that would be paid to a civil servant or worker with disability, but there are no obvious instances or mechanisms of the PwDF to collect these fines – a report in 2016 revealed how the PwDF had not collected one fine (Hutt, 2016), and this was corroborated in interviews with representatives of the PwDF. As of 2010 there were still less than 2% of in the Cambodian civil service with disabilities (David, 2019). In 2012, a decree formed by MoSVY and MoLTY was announced to support the implementation of this quota by providing guidelines on the development of a recruitment plan and reasonable accommodation in the employment of persons with disabilities to carry out duties, roles and responsibilities of a particular position without discrimination, but this has failed to be implemented effectively (UNPRPD, 2021). A representative from the CMAA – a person with disabilities – stated that the framework on employment, the law and policy are good, but in reality, nothing is being done. He stated, in addition, that there needs to be better regulation on adjusting the workplace to fit the requirements of persons with disabilities. The 2%/1% quota is not enough, we need to know whether these employed people are having meaningful participation in their workplace, as, he claimed, many employers, including the government just employing persons with disabilities because they need to hit the quota, rather than making suitable adjustments so that these employees can participate at work.

The Department of Welfare for Persons with Disabilities (DWPD) hotline number 1270 is being implemented to provide persons with disabilities (also accessible to those with hearing disabilities) to log for complaints related to disability affairs, including employment. It is not clear whether there have been any complaints made about public and private employment.

Speaking on employment of persons with disabilities, the Minister of the MoSVY urged public and private institutions to go beyond the quota of employment for persons with disabilities, encouraging more physically accessible infrastructure, claiming that stating that, "Society's rejection of hiring people with disabilities or giving them job opportunities, education, or other access to other services is not only unfair to them, but it also overlooks valuable human resources and deprives society of them" (Samean, 2022). The DRA collects data on the number of persons with disabilities employed in government agencies and the private sector, and, in 2019, there were 2,860 civil servants with disabilities (1.95%) working in government institutions, and 102 private sector entities were, collectively, employing 3,792 persons with disabilities (David, 2019). NSDP2 acknowledges the challenges in implementing the

employment of persons with disabilities, especially in the private sector, and that the DRA and other entities face capacity issues (Royal Government of Cambodia, 2019).

The National Mine Action Strategy 2018-2025 (The Royal Government of Cambodia, 2017) and the additional CSDG, Goal 18 to "Promote the rights and improve the quality of life of persons who have disabilities due to landmine/ERW accidents" (Kingdom of Cambodia, 2019, p. 82), bolsters the efforts of the broader efforts: the CMAA, as well as supporting the vocational training of almost 650 persons with disabilities, helped 23 access job placements, and provided 24 bicycles to help survivors and persons with disabilities access work.

To directly support EO victims and persons with disabilities in Battambang the BDPO has established a centre in collaboration with the ICRC to provide employment opportunities and small grants to those who are using and have been referred by the rehabilitation centre. In addition to the education support that the CMAA provided, they interviewed and referred 493 persons with disabilities to other service providers for vocational training schemes, helped 23 access job placements, 33 women with disabilities attend sporting events, and provided 24 bicycles to help survivors and persons with disabilities access work. Additionally, according to the CMAA (2023) clients of the PRCs across Cambodia attended the gender training, job placement, and small business management training courses. The ACCESS programme had success in engaging persons with disabilities in socioeconomic improvement programmes, with 1,541 disability stakeholders trained in developing skills to facilitate access to economic opportunities through their 'Oakas' employment app, which ACCESS reported contributed in part to a 17% a 35% increase in public and private sector employment, respectively between 2020 and 2021 (Urbano, Vesely, Hardefeld, Lim, & Naughton-Watt, 2023). ACCESS also trained 45 employers in disability inclusion policies, and connected eight OPDs with the RGC to improve social protection for persons with disabilities – for example 838 members to access social protection payments (ibid., 2023).

There is an economic benefit to investing in a disability inclusive economy for the individual and for society as a whole. Walton (2012) argues that the main reason for this is the relation with costs. Costs of a non-inclusive economy to the individual include: additional costs of disability loss of income for people with disabilities and their families due to lower pay and unemployment; loss of education for people with disabilities and their families/households; lack of access to credit schemes. And costs to the state/society include: loss of productivity; loss of taxes public spending on disability programmes (Walton, Economic Benefits of Disability-Inclusive Development, 2012). A report by the UNDP on Transforming Urban Mobility in Phnom Penh[41] is a good[42] example of an initiative to develop transport and infrastructure in Cambodia in a way that benefits all, and is inclusive of considerations for persons with disabilities, ensuring that access to work, healthcare, and other key sites will be equitably accessible as per the responsibilities of Cambodia under the CRPD (UNDP, 2021). Examples of supporting mobility for persons with disabilities already exist in Phnom Penh, such as free transport on the public bus service (with an identification card), and universal access of sidewalks for persons with disabilities in Preah Norodom Boulevard (ibid., 2021).

[41] https://www.undp.org/cambodia/publications/transforming-urban-mobility-phnom-penh
[42] The document would have benefitted to more specific references to specific accessibility mechanisms for persons with disabilities.

5. Discussion

According to their international commitments and national frameworks, the RGC's responsibility, through the relevant ministries with the support of NGOs, is to take all appropriate measures to ensure that public services and social protection and assistance mechanisms in Cambodia are equally accessible to, and inclusive of, EO victims and persons with disabilities.

The considerations presented in this discussion are drawn from the information presented in this section on Cambodia's relevant frameworks and the inclusivity of service provision, collected from the document analysis and interviews with leading VA stakeholders in Cambodia. The aim of this discussion is to highlight areas within Cambodia's VA system that require revision or reinforcement to enhance Cambodia's support for EO victims and persons with disabilities and ensure that the RGC fulfils its obligations to the relevant international conventions and associated documents.

5.1. Humanitarian Mine Action Victim Assistance in Cambodia

Information Management and Inclusive Governance

The CMAA serves one of its core functions as Cambodia's NMAA, data management, through the CMVIS and the QLS conducted over the past two years. Mapping victims and services through the QLS generates quantitative indicators of victims' needs and the outputs and outcomes of services and programmes. These indicators have the potential to aid broader VA stakeholders - such as the MoEF, the MoH and MoSVY - better manage their resources by helping them to identify gaps in the VA system. Once effectively analysed and visualised in a digital format, this data can also be used by the CMAA to audit activities and verify the compliance of obligations under international conventions, and advocate for increased funding (if necessary) from the international sector. The QLS also has the potential to identify and target recipients of programmes, and the CMAA, through its QLS and volunteer network, can strengthen the referral mechanisms and cooperation between local communities and national frameworks.

Despite efforts by the CMAA to collect and disseminate information on the services for, and needs of, EO victims and persons with disabilities, the referral system between service users and service providers is still limited. In this sense, the QLS is not being fully utilised to improve referral capabilities. The information gathered by the QLS should be used by the CMAA and its partners (e.g. MoH, MoSVY) to inform an effective (digital) VA data management system that facilitates referral to general and mine action-specific support. Additionally, expanding the reach of the QLS should be a priority for the CMAA until it covers all provinces (beyond the three provinces it is being piloted in). The analysis of the information gathered by the QLS should also integrated (where possible) with other information systems on disability, health, and social protection, with a central body such as MoSVY managing the amalgamation and analysis of digital data. Over time, the QLS (or a more integrated and advanced system) could be used to monitor the changing levels and types of needs within Cambodia, as well as measure the impact of VA programmes. Such data analysis will be invaluable when planning resource mobilisation and implementing strategy at the national and subnational level.

Data and information collected and analysed by the CMAA and its partners should also be disseminated to all relevant government entities (national and subnational), development partners, self-help groups, and local leaders, raising awareness among both service users and service providers on victims' needs, disability rights, and other critical information. Making information accessible to service providers and persons with disabilities (including those with sensory and intellectual disabilities) is critical for participation and representation in governance and policy, and should be championed by the CMAA. An example of an action to champion disability inclusion through the dissemination of accessible information could involve the CMAA utilising data from the QLS to identify persons with hearing disabilities, then, in a partnership with the MoSVY, the MoEYS, and deaf-focused OPDs, establish community outreach programmes such as sign language lessons for adults and parents with children with disabilities, while incorporating sign language into schools where required. This will enhance the general understanding of EO victims and persons with disabilities and, through education, lead to a more inclusive society.

Beyond data management, the CMAA should work to stimulate cross-party collaboration between broader government VA actors as, currently, the ministries providing the most important services to EO victims (MoH and MoSVY) are atomised and their approaches are detached (rather than integrated). One example highlighting this barrier to coordination is a joint-strategy for rehabilitation services that was drafted by the MoSVY and the MoH in 2018, with the support of the WHO. The strategy outlined a cooperative approach to rehabilitation, but a lack of agreement between the two ministries meant that the strategy was never published. To overcome such barriers to cooperation, the CMAA should continue to act as a catalyst for VA stakeholders and activities - government and non-government – and, where possible, increase working groups, forums, events, and platforms for information sharing and collaborative partnerships. The CMAA should also be included in all national policy and strategy developments relating to public services and social protection to ensure that they are inclusive of EO victims - including the revision of the Disability Law, the Family Package, and the establishment of a Mental Health Strategic Plan.

The participation and representation of survivors in public decision-making and policymaking, especially OPDs and EO survivor organisations, is limited. The CMAA should increase the dissemination of information on government law, policies, and programmes in accessible formats, and enhance advocacy for the inclusion of EO victims and persons with disabilities across national policymaking and coordinating bodies, especially (but not exclusively) those that are not disability-focused. Participation of EO victims and persons with disabilities, as well as the dissemination of information, should be extended to subnational structures, as, according to interviews with senior representatives from the RGC's ministries, the provincial level administrators are not as aware of disability rights (national and international) as those at the national level.

The Implementation of Service

A full range of services is not available across the 25 provinces and the reduction in humanitarian funding over the past years is causing significant challenges for NGO service providers, according to interviewed NGO leaders. The 'Decentralisation and Deconcentration Reforms' are making subnational

administration more important to service delivery for EO victims and persons with disabilities (The World Bank, 2021). Although ACCESS has supported 10 of the provincial DAC offices, according to their representative's responses in an interview, there are 15 provincial offices that have not been supported, and, according to various NGO leaders, are struggling to provide community level support: the number of local NGOs and OPDs has reduced, and those that remain do not have enough funding to visit communities and provide support. In addition to a national framework for VA, there needs to be functional structures at the subnational and community level to support national mechanisms, as well as provide multi-entry support.

By engaging and enhancing community organisations through the coordination of local authorities, NGOs, OPDs, the CMAA can help to facilitate healthcare and social protection outreach; identify appropriate recipients of programs, monitor implementation, collect, and disseminate information; and manage and distribute resources (including staff). Utilising a public entity such as the CMAA VA team to enhance the work of OPDs, local organisations and community leaders can bolster the work of national socioeconomic and health policy implementation. The executive director of one community-based rehabilitation programme, DDSP, the only national NGO interviewed, claimed that there should be a "follow up system at the commune or district level, at least [on a] quarterly basis, and a working group or steering committees to monitor and ensure persons with disabilities fully benefit from programmes and policy". He stated that there needs to be improved capacity of local authorities to collect and analyse data, as well as the enhanced capacity of self-help organisations and local NGOs to support their communities at the community level. The CMAA could use mine action VA as a catalyst to coordinate outreach projects to provide key services for EO survivors and persons with disabilities at the community level, in bolstering and working in partnership national mechanisms managed by the MoH, MoSVY, MoEYS, and other ministries.

In regard to the forthcoming revision of the Disability Law, there needs to be a comprehensive implementation plan to ensure the rights under this law are upheld, including detailed budgeting (e.g. a specific budget within ministerial budget that must be spent on activities for persons with disabilities), clear regulations (e.g. employment quotas), and mechanisms to penalise non-compliance. There also needs to be an increased focus on the (resource and expertise) capacity development of the relevant ministries (DAC, MoSVY, MoH, and the PwDF) to bolster this implementation effort, and an improvement in the coordination between ministries and RGC agencies, as well as between public entities at the subnational and implementation level, EO survivor organisations and OPDs, the private sector, and the NGO sector. The CMAA should contribute an integrated approach with these broader actors, representing the perspective of EO VA, utilising its data management and awareness raising capabilities.

5.2. Broader Victim Assistance in Cambodia

Relating to all of the below sectors, one of the most severe and widespread barriers to the inclusion of EO for victims and persons with disabilities in society is physical access to public transportation and other public services, and public areas. Without the general improvement of accessible infrastructure and transport, the inclusiveness of services will be largely undermined. The same is true for the inclusion of people with disabilities in decision-making and policymaking, and a general access to accessible information on disabilities, needs, and services.

Medical Care

The public healthcare system is still not equipped to deal with the demands of Cambodian citizens – including EO victims and persons with disabilities - and is still reliant on NGOs. The public healthcare system, therefore, requires vast funding, staff, and expertise improvements in order to move closer to the goal of universal health coverage.

It was the general consensus from interviews and a review of prior research that persons with disabilities in Cambodia often avoid necessary healthcare because they cannot afford the direct and associated costs and/or loss of income while accessing care. Any social protection or financial support scheme related to medical care and rehabilitation must take a holistic approach and consider the loss of income alongside the direct cost of care and other associated costs such as transportation and accommodation. As many EO survivors and persons with disabilities will need to travel to the healthcare or rehabilitation centre with a member of the family (and possibly children) the costs and lost income for the companion should also be considered.

Government-run first aid, emergency evacuation, and emergency care capabilities in rural areas need to be expanded and improved to reduce the risk of avoidable death and long-term affliction of explosive harm. There also needs to be an increase in the number of specialist medical staff in government facilities who can conduct required surgeries at the provincial level, and an increase in the number of doctors and other medical staff at the local level. Incentives to attract staff from the private sector and abroad are necessary to achieve this – incentives such as increased salary, subsidised training and education, subsidised housing and family costs, benefits of tenure such as attractive pensions. To encourage recruitment of new medical professionals, students should be financially supported to train as medical professions in return for a specified term (such as 3 years) in the Cambodian public healthcare sector (with the alternative option of paying off the cost of training/education).

Until the capacity and capability of Cambodia's general healthcare sector improves, especially at the subnational level, there needs to be bespoke financial support targeting persons with disabilities that allows them to access emergency and continuing medical care. To ensure this is achieved, hospitals and local entities of the MoH should use the new identification system and identity cards for persons with disabilities to ensure that medical support is available and free for persons with disabilities. There also needs to be effective collaboration between medical care and the other areas of assistance for persons with disabilities – MHPSS, rehabilitation, and socioeconomic support – through improved coordination between ministries and referral mechanisms. Hospitals and local medical centres, for instance, should communicate with the disability identification system and the new Family Package scheme to ensure that costs related to preventing avoidable health issues (e.g. proper nutrition and housing) and accessing healthcare are considered. In addition, to make healthcare more affordable, health insurance schemes linked to employment need to expand to those with disabilities working in the informal sector.

Mental Health and Psychosocial Support

MHPSS services are critically underdeveloped in Cambodia and there is a requirement for an improvement in both framework (strategic plan) and capacity (staff, funding, and resources). As a result

of an underdeveloped system, thousands of EO victims and persons with disabilities in Cambodia experience ongoing mental health difficulties. To rectify this, there needs to be significant investment in the development of a MHPSS systems with input from the MoH, MoSVY, MEYS, MoLVT, MoEF and other relevant government entities. Collaboration between these stakeholders, including information sharing, referrals, multidisciplinary approaches all need to be improved. Mental health also needs to be integrated into the primary, secondary, and tertiary healthcare stages, as well as integrated into other public services such as education.

Any mental health strategic plan will need to consider the context of Cambodia and the influences of religion and spirituality, rather than simply adopting the western style of MHPSS. It also will need to consider the sources of mental health challenges, and work in cooperation with other sectors (healthcare, rehabilitation, social protection) to address the causes while alleviating the effects. And finally, a strategic plan needs to establish standards of quality control, professionalism, an ethical framework, and monitoring and evaluation mechanisms.

There needs to be a vast improvement in the understanding and support for persons with intellectual disabilities in Cambodia. For all forms of disabilities, proper awareness raising is necessary in healthcare, education, and employment facilities, and among local communities and families. Until an improved understanding of mental health and disabilities in Cambodia is established, there will be continued discrimination and mistreatment of those with of mental health disorders and cognitive disabilities. With better public knowledge, people will have more choice and better tools to seek out support. Ministerial leaders also need to ensure that they are aware of mental health to establish proper policy and provide suitable public services.

Physical Rehabilitation

Rehabilitation services do not function country-wide, making them inaccessible to many people. They are also on the verge of collapse (in the words of those running them) meaning that they may soon become difficult to access and expensive for EOs and persons with disabilities if steps are not taken to stop this.

Staff recruitment and retention are at dangerously low levels, with many staff operating and working in PRCs looking to retire. The aging population within the rehabilitation sector puts the country at risk of a severely reduced capacity to provide rehabilitation services. There should be a focus on improving the incentives to study to become POs and POTs, as well as the incentives to work for the public sector i.e. increased salary, job security, pension, subsidised education.

The rehabilitation sector in Cambodia is heavily dependent on external funding and support from international organisations such as EXCEED Worldwide, the ICRC, and HI. The capacity, productivity, and output of PRCs managed by the PwDF lack human and material resource capacity. The entire rehabilitation sector is currently functioning unsustainably, even after huge capacity reduction over the past 10 years.

Due to the steady reduction of staff, funding and capacity in the rehabilitation sector, the current system under MoSVY and the PwDF is unsustainable. Responsibility and existing resources (staff, buildings, equipment) for providing services should be transferred across to the MoH with the full support of both government and non-government stakeholders, including MoSVY. Based on the testimonies from interviews, there is a universal agreement among VA stakeholders that the transfer of responsibility to provide rehabilitation, along with human resources, material resources, and buildings and land from MoSVY to the MoH would improve the sustainability and effectiveness of the rehabilitation sector. It was also agreed by EXCEED Worldwide, HI, and the ICRC, that transferring the responsibility to provide services without the material capacity to do so will have a detrimental effect on the MoH's ability to support EO victims (and other persons) who require these services. There also needs to be improvements to administrative systems, which, according to EXCEED Worldwide, exists in the MoH. It was also the general consensus among the interviewees that the transition would reduce costs and improve services and referrals. The transfer of responsibility of physical rehabilitation services to the MoH should also improve and increase hospital-based rehabilitation services, with rehabilitation centres attached to hospitals to enhance the synergy between rehabilitation and medical care.

Regarding the financial sustainability of the PRCs, although free rehabilitation services make them more accessible to service users, providing free rehabilitation services to all persons with disabilities - as claimed by interviewed representatives from EXCEED Worldwide, the UNDP, and the ICRC – is not a sustainable financial plan and needs to be revised. The sector will need to consider charging for services to those who can afford it, but users' ability to pay for services needs to be carefully measured and assessed, developing a metric that considers a multitude of financial factors systematically. Any approach needs to be contextual, with consideration and appropriate support for those who cannot afford services, including consideration for associated costs and lost income when seeking out rehabilitation.

Even once the availability of free services is reduced, the cost of providing services and equipment is high. Each prosthesis, for instance, costs around USD300 to make according to the director of the PwDF. Without new technology and/or more economical supply chains, the RGC is not going to be able to afford to provide prosthetics. As well as reducing the availability of free services, financial plans will need to consider the development of new technologies, including sustainable supply chains including recycling, alternative materials (see Bamboodia) and 3D printing. Another consideration for the financial strategy is to stimulate income through social enterprises such as paid schooling and exporting components and products. This is a strategy that is currently being explored by rehabilitation NGOs in Cambodia.

As a final comment, the movement of workshops and referral buildings from populated to rural areas decreases the accessibility for the aging staff and should be halted and reversed where possible.

Socioeconomic Support and Social Protection

Since the adoption of the SPPF and the operationalisation of the National Social Protection Council in 2018, the sphere of social protection has transformed quickly, and the Family Package is the latest example of that transformation. Over the past five years, the RGC has improved the process for

identification and the digitisation of data, consolidated existing structures and programmes, digitized social assistance benefits, and developed a national monitoring and evaluation framework. Combine this with the initiation of MoSVY's identification for persons with disabilities roll out, and there is a huge opportunity for Cambodia to become a best practice model in regard to inclusive and responsive lifecycle social protection for EO victims and persons with disabilities.

The new Family Package system overcomes the fragmented social protection and assistance mechanisms that have been in place, consolidating support and centralising data, making it easier to track and target support. The monitoring and financing of social assistance will also be consolidated under the Family Package, reducing costs through improved efficiency and minimising overlap, as well as making it easier to refer people to coordinate complimentary programmes through this centralised system.

However, the opportunities are not yet realised and the evidence of the impact of the Family Package is unavailable. Commenting on previous social policy, implementation of social protection programmes, including the provision of social assistance, has only reached a minority of the estimated population of EO victims and persons with disabilities (especially in rural areas), largely due to the lack of financial resources of the RGC. The RGC needs to ensure that the new 'Family Package' policy (as with policies discussed) is funded properly, implemented effectively, and that databases are established and utilised, and that other services such as education and healthcare are considered, to form an informed, auditable, and integrated multi-sector approach. There also needs to be multi-level collaboration (for multiple entry points), including those at the community level such as OPD and EO survivor organisations, as well as the NGO sector. The more centralised, coordinated, and integrated the system becomes, the more that compounded efforts (and positive outcomes) will increase and costs will reduce (as the socioeconomic status of Cambodia's citizens rises). Centralisation will require the development of standards and an effective implementation plan, alongside a suitable and sustainable funding strategy. The implementation plan must include monitorable indicators, quality assurance processes, standards, and a detailed budget with intelligent forecasting.

A significant cost of the new Family Package strategy will be sufficient staffing and training, which will be critical to the success of the project. There will need to be proper safeguarding, welfare and quality assurance standards, training and monitoring mechanisms in place, especially for staff working with vulnerable groups. Once established, this workforce will need to work on a case-by-case approach to identify vulnerable or potentially vulnerable individuals as quickly as possible to reduce the risk of sever or long-term consequences of poverty for the individual and society. The system will also need to be resistant to shocks such as pandemics and environmental crises.

The CMAA should use their victim mapping activities (CMVIS and QLS) to work with broader stakeholders to improve social protection and assistance referral and targeting. For instance, the process to attain the IDPoor can be hindered by flawed identification and classification, and a complex and protracted application process. By identifying those who need financial support through the QLS, the CMAA should – in collaboration with OPDs and EO survivor organisation and relevant ministries – help the RGC target those who need financial support through the new Family Package to improve the reach of social protection measures. In addition, those identified through the QLS should be the subject of outreach programmes to ensure they gain disability identification that allowed them certain access to free healthcare and other services such as bus transport in Phnom Penh.

More economic opportunities and income-generating schemes for persons with disabilities, including EO victims, need to be established. Ways to achieve this include an increased number and variety of vocational training schemes, and improved education staff and facilities in place to support persons with disabilities. There should also be an increased number of jobs reserved for persons with disabilities in the public and private sector. To achieve this, there should be an enhanced focus on public-private cooperation such as tax deductions for employers who employ persons with disabilities. There also needs to be an increase in the public and private sector quota for employment of persons with disabilities, and accountability mechanisms need to be implemented to punish employers – including the civil service – that do not comply with the quotas. Moreover, inspections and surveys to assess the adaption of workplaces to accommodate for the meaningful participation of persons with disabilities should be introduced.

Like with the disability law, there needs to be a more detailed implementation plan for the NDSP i.e. budget, implementation standards, monitoring, and evaluation mechanisms.

There needs to be a fundamental shift in the policy surrounding accessibility of transportation, public spaces, buildings, and information, including accessibility for those with sensory and intellectual disabilities. This should be embedded in the new Disability Law, and representation of persons with all forms of disabilities should be represented, through OPDs in policymaking where possible.

6. Concluding Statement

Cambodia has a comprehensive collection of national laws, policies, plans, and strategies that have the potential to frame a society that supports and includes EO victims and persons with disabilities, but challenges remain. A fundamental issue is the inadequate consideration of persons with disabilities in the RGC's general decision-making and policy and the limited inclusion of EO victims and persons with disabilities in governance and the design and implementation process of policy and law. Without consideration and inclusion of persons with disabilities in both general and VA- and disability-focused policymaking and governance, the system cannot be considered inclusive. There is also a lack coordination between entities within the RGC, curbing the progress and efficacy of policy development and implementation. Compounding these issues is a lack of trained staff, resources, and funding to implement VA-relevant strategy and policy, which hinders accessibility to critical services and support for EO victims and persons with disabilities.

Building a Cambodian society that fully supports and is inclusive of EO victims and persons with disabilities will not be easy, but the RGC and its development partners have begun building strong foundations and frameworks that can make this possible. If the RGC expands and deepens the inclusion of EO victims and persons with disabilities in decision-making and policymaking, and commits to enhancing and effectively implementing its existing VA-relevant policies with suitable funding and resources (supported by the international community), it has the potential to become a model of victim assistance best practice for other affected AMS, and countries affected by EO worldwide.

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Appendix

Appendix I: Key Definitions

Humanitarian Mine Action and Victim Assistance

Humanitarian Mine Action

Humanitarian Mine Action encompasses five categories or pillars of activity, in place to mitigate the impact of landmines and explosive ordnance harm. These activities consist of: clearance, explosive ordnance risk education (EORE), advocacy, stockpile destruction, and, the subject of this paper, victim assistance.

See: https://www.unmas.org/en/5-pillars-of-mine-action for information on the other five pillars of VA.

Victim Assistance

In accordance with Article Six of the APMBC, "Each State Party in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims and for mine awareness programmes.". (United Nations, 1997)

IMAS 13.10 (amendment January 2023) specifies victim assistance as "broader and specific efforts to address the needs and rights of victims" with 'specific efforts' "undertaken by the mine action sector to contribute to facilitating access to VA services" and 'broader efforts' "undertaken by sectors other than the mine action sector, including delivery of VA services, data collection, coordination, laws and policies" (UNMAS, 2023, p. 2). IMAS 13.10 also specifies VA services to include emergency and continuing medical care, rehabilitation, psychological and psycho-social support, and socio-economic inclusion (UNMAS, 2023).

Please see Annex B (pp. 9-11) of the IMAS (2023) 13.10 document on Victim Assistance in Mine Action, and the Geneva International Centre for Humanitarian Demining (GICHD) (2008) Guide to Understanding Victim Assistance in the Context of the AP Mine Ban Convention for more detail on the elements and activities of victim assistance.

Survivor Organisation

"organization representing and working in the interest of survivors, other persons with disabilities and indirect victims, which includes survivors and/or indirect victims in its structure." (UNMAS, 2023, p. 3)

Note on Survivor Organisations from IMAS 13.10, amendment January 2023

"EO survivor organizations are created by and for the benefit of victims and persons with disabilities and often contribute unique experience-based peer-to-peer support and referrals. They may provide other services by which the victims' different needs can be addressed. They generally also provide survivor-led advocacy, awareness raising and community mobilization, and contribute to coordinating VA. It is also possible for survivors to be engaged with organizations of persons with disabilities (OPDs, formerly known as DPOs or disabled person's organizations). These are nongovernmental organizations led, directed, and governed by persons with disabilities, who should compose a clear majority of their membership. EO survivor organizations and OPDs play a critical role by serving." (UNMAS, 2023, p. 3)

Referral

"referral delivery of information on available services to victims" (UNMAS, 2023, p. 3)

Referral mechanism

"a system for identifying, protecting, and assisting people injured by EO, survivors, other persons with disabilities and indirect victims and connecting them to needed victim assistance services (or providing them with "information on available services"). Example: For instance, making a referral to medical care or psychosocial support for an indirect victim expressing need for care." (UNMAS, 2023, p. 3)

Survivors, Victims, and Persons with Disabilities

Victim

"Persons who have experienced physical, emotional and/or psychological injury, economic loss; whose recognition, enjoyment or exercise of their human rights on an equal basis with others has been hindered; or whose full and effective participation in society has been restricted by an accident with a confirmed or suspected presence of explosive ordnance" (UNMAS, 2023, p. 2)

Direct Victim

"person killed, injured and/or impaired as a result of an accident with EO.'" (UNMAS, 2023, p. 3)

Survivor

"direct victim who has been injured and/or impaired, but not killed as a result of an accident with EO" (UNMAS, 2023, p. 3)

Notes on this definition from the IMAS 13.10 document, amendment January 2023

"Note 1 to entry: "Survivor" is a subgroup of "direct victim"."

"Note 2 to entry: The term "survivor" should be used for persons who survived. The term "victim" should be used when referring to the broader groups of victims, in line with applicable legal obligations regarding gross violation of international human rights law, and serious violations of international humanitarian law. However, some people identify more as victims, others as survivors. There is no single term that captures everyone." (UNMAS, 2023, p. 3)

Indirect Victim

"family members of direct victims, as well as individuals and communities affected by EO." (UNMAS, 2023, p. 3)

Disability

Disability is a complex, dynamic, and multifaceted concept. There is yet to be a universally accepted definition of disability. In recent years, the focus of defining 'disability', however, has turned from purely medical classification to include social influence, with more consideration for contextual and environmental factors.

As such, this report follows the WHO's description of disability as the result of "the interaction between individuals with a health condition, such as cerebral palsy, Down syndrome and depression, with personal and environmental factors including negative attitudes, inaccessible transportation and public buildings, and limited social support" (World Health Organisation, 2021).

Weapon Types

Explosive Ordnance (EO)

Explosive ordnance (EO) "is interpreted as encompassing mine action's response to the following munitions: mines; cluster munitions; unexploded ordnance; abandoned ordnance; booby traps; other devices (as defined by CCW APII); improvised explosive devices" (UNMAS, 2023, p. 2)

Landmine/mine

"a mine designed to be exploded by the presence, proximity or contact of a person and that will incapacitate, injure or kill one or more persons." (United Nations, 1997).

If an anti-vehicle landmine is referenced in this paper – a mine designed to explode in the presence, proximity, or contact of a vehicle – it will be specified.

Cluster munitions

"conventional munition that is designed to disperse or release explosive submunitions each weighing less than 20 kilograms, and includes those explosive submunitions." (Convention on Cluster Munitions, 2008)

Unexploded Ordnance (UXO)

"explosive ordnance that has been primed, fused, armed, or otherwise prepared for use and used in an armed conflict. It may have been fired, dropped, launched or projected and should have exploded but failed to do so." (ICRC, 2005, p. 50)

Abandoned Explosive Ordnance (AXO)

"explosive ordnance that has not been used during an armed conflict, that has been left behind or dumped by a party to an armed conflict, and which is no longer under control of the party that left it behind or dumped it. Abandoned explosive ordnance may or may not have been primed, fused, armed or otherwise prepared for use." (ICRC, 2005, p. 50)

Explosive Remnant of War (ERW)

Encompasses unexploded ordnance and abandoned explosive ordnance.

Booby Traps

"any device or material which is designed, constructed or adapted to kill or injure, and which functions unexpectedly when a person disturbs or approaches an apparently harmless object or performs an apparently safe act." (ICRC, 2005, p. 24)

Other Devices

"manually-emplaced munitions and devices including improvised explosive devices designed to kill, injure or damage and which are actuated manually, by remote control or automatically after a lapse of time." (ICRC, 2005, p. 24)

Appendix II: Victim Assistance Responsibilities, Activities, and Best Practices

Best practice of victim assistance within the context of Cambodia is based on the laws and policies it has signed and ratified - based on the victim assistance obligations to the **Anti-Personnel Mine Ban Convention (APMBC)** and, as a rights-based study, has been guided by the **Convention on the Rights of Persons with Disabilities (CRPD**). The classification on Cambodia's VA responsibilities has principally been guided by these two documents as well as the following:

- The Convention on Cluster Munitions (CCM)
- The Convention on Certain Conventional Weapons (CCW)
- International Covenant on Civil and Political Rights (ICCPR)
- The Convention on the Rights of the Child (UNCRC)
- The International Covenant on Economic, Social and Cultural Rights (ICESCR)
- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Associated with these various legally-binding documents, Cambodia has indicated support for other related documents, with the two highlighted being the most influential over the classification of Cambodia's responsibilities, appropriate activities, and best practices:

- Anti-Personnel Mine Ban Convention Action Plans
  - Nairobi Action Plan
  - Cartagena Action Plan
  - **Oslo action Plan**
  - **International Mine Action Standards (IMAS) 13.10 Victim Assistance**
- The WHO World Disability Action Plan 2014-2021
- The Humanitarian Charter
- The Charter on the Inclusion of Persons with Disabilities in Humanitarian Action
- The Humanitarian Inclusion Standards for Older People and People with Disabilities
- The IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action
- The 2030 Agenda for Sustainable Development (SDGs)

The study also considered national laws, policies, and strategies in place to protect and promote the rights of landmine survivors, victims, and people with disabilities.

Victim Assistance and Cross-Cutting Actions within The Oslo Action Plan

Following are a non-exhaustive lists of responsibilities and best practices Integrated and adapted from the most influential documents that guided the classification of Cambodia's responsibilities, appropriate activities, and best practices: the Oslo Action Plan, IMAS 13.10, the CRPD, and the United Nations Policy on Victim Assistance in Mine Action– see the respective documents for more details.

Actions that apply to states with victims, which must

1. **(Article 1)** Demonstrate high levels of national ownership, including by integrating Convention implementation activities into national development plans, poverty reduction strategies, humanitarian response plans and national strategies for the inclusion of persons with disabilities as appropriate, and by making financial and other commitments to implementation.
    a. The States Parties have defined national ownership as entailing the following: 'maintaining interest at a high level in fulfilling Convention obligations; empowering and providing relevant State entities with the human, financial and material capacity to carry out their obligations under the Convention; articulating the measures its State entities will undertake to implement relevant aspects of Convention in the most inclusive, efficient and expedient manner possible and plans to overcome any challenges that need to be addressed; and making a regular significant national financial commitment to the State's programmes to implement the Convention'.
2. **(Action 3)** Ensure that the different needs and perspectives of women, girls, boys and men are considered and inform all areas of victim assistance, in order to deliver an inclusive approach. Strive to remove barriers to full, equal and gender balanced participation in mine action and in Convention meetings. Provide quality information on progress and challenges in implementing the Convention, including on cooperation and assistance, by 30 April each year in line with Article 7, employing the Guide to Reporting[2], and during formal and informal meetings.
3. **(Action 4)** take into consideration the needs of mine survivors and affected communities and ensure their meaningful participation in society.
4. **(Action 34)** Carry out multi-sectoral efforts to ensure that the needs and rights of mine victims are effectively addressed through national policy and legal frameworks relating to disability, health, education, employment, development and poverty reduction, in line with the relevant provisions of the Convention on the Rights of Persons with Disabilities
5. **(Action 36)** provide effective and efficient first aid to casualties in mine-affected communities, as well as other **medical emergency services, and ongoing medical care**.
6. **(Action 38)** take steps to ensure that, taking into account local, national and regional circumstances, all mine victims, including in rural and remote areas, have access to comprehensive **rehabilitation** services and **psychological and psychosocial support** services, including through the provision of outreach rehabilitation service, where necessary, while paying particular attention to the most vulnerable, including the provision of assistive devices, physiotherapy, occupational therapy and peer-to-peer support programs.
7. **(Action 39)** carry out efforts to ensure the **social and economic inclusion** of mine victims, such as access to education, capacity-building, employment referral services, microfinance institutions, business development services, rural development and social protection programmes, including in rural and remote areas.
8. **(Action 40)** ensure that relevant national humanitarian response and **preparedness plans provide for the safety and protection of mine survivors in situations of risk**, including situations of armed conflict, humanitarian emergencies and natural disasters, in line with relevant international humanitarian and human rights law and international guidelines.
9. **(Action 41)** ensure the full inclusion and effective participation of mine EO victims and persons with disabilities and their representative organizations in all matters that affect them, including in rural and remote areas.

Actions Targeting HMA-Specific Stakeholders

1. **(Action5)** Keep national mine action standards up to date in accordance with the latest International Mine Action Standards (IMAS), adapt them to new challenges and employ best practices to ensure efficient and effective implementation.
2. **(Action 6)** Strengthen partnerships and integrate responses between the mine action community and relevant humanitarian, peacebuilding, development and human rights communities, bearing in mind the 2030 Agenda for Sustainable Development.
3. **(Action 8)** Provide quality information on progress and challenges in implementing the Convention, including on cooperation and assistance, by 30 April each year in line with Article 7, employing the Guide to Reporting2, and during formal and informal meetings.
4. **(Article 9)** Establish and maintain a national information management system containing accurate and up-to-date data at the national level on the status of implementation. The design and implementation of information management systems will ensure that they are nationally owned, sustainable and take into account the need for data that can be accessed, managed and analysed post-completion.
5. **(Action 33)** Develop an action plan and monitor and report on implementation based on specific, measurable, realistic, and time-bound objectives to support mine victims. This involves the removal of physical, social, cultural, political, attitudinal and communication barriers to access such services; and the use of an approach that is inclusive of gender, age and disability and takes diverse needs into account in planning, implementation, monitoring, and evaluation of all programmes.
6. **(Action 35)** Strengthen a centralised database that includes information on persons killed by mines as well as on persons injured by mines and their needs and challenges, disaggregated by gender, age and disability, and make this information available to relevant stakeholders to ensure a comprehensive response to addressing the needs of mine victims.
7. **(Action 37)** Ensure, where appropriate and possible, a national referral mechanism to facilitate access to services for mine victims, including by creating and disseminating a comprehensive directory of services.

Best Practices for Implementing the Actions of the Oslo Action Plan (3.5. – p.27)

- Strong national ownership;
- evidence-based national strategies and workplans;
- integrating and mainstreaming gender considerations and taking the diverse needs and experiences of people in affected communities into account in mine action programming;
- efficient use of available resources, including through the use of the latest methodologies in line with the International Mine Action Standards (IMAS);
- partnership, coordination, and regular dialogue between stakeholders;
- national and international resource commitments, where possible on a multi-year basis;
- transparency and the exchange of high quality and accurate information in line with the Convention obligations;
- accurate and sustainable national information management systems;
- the effective functioning of the Convention's implementation machinery, including the work of the Committees, the support provided by the Implementation Support Unit and the holding of Meetings of the States Parties.

IMAS 13.10 and the United Nations Policy on Victim Assistance in Mine Action Adapted to the Context of Cambodia

(IMAS 13.10 5.1.1) The CMAA (NMAA) should:

1. Collect, analyse data on victims and their needs, and disseminate this data with relevant government and non-government actors;
2. communicate government policies, guidelines, and structures to support victims;
3. assist broader government and non-government systems and a actors responsible for the provision of VA services (e.g. MoH, Ministry of Social Affairs, Veterans Affairs, and Youth (MoSVY), the International Committee of the Red Cross (ICRC)), in the development of their programmes;
4. compile a directory or a guide of services available to victims that is accessible to stakeholders (victims, service providers, local leaders etc.
5. develop national standards that explain the roles and responsibilities of the mine action sector within Cambodia's multi-sector approach to VA;
6. ensure that HMA stakeholders in Cambodia use established referral mechanisms when engaging in VA;
7. participate in existing inter-ministerial and multi-stakeholder coordination mechanisms related to VA and disabilities and advocate for the inclusion of victims and other persons with disabilities in these mechanisms;[43]
8. collaborate with relevant ministries (e.g. the MoH, MoSVY) to conduct a nationwide needs assessment of survivors and persons with disabilities to enhance planning and programming, with specific focus on the impact of EO within that assessment;
9. support appropriate national bodies responsible for the creation and implementation of a national VA action plan that is synchronised with, and is included in national legislation, policies and programmes related to health and disability;
10. promote community-based planning processes that facilitate the active participation of survivors – establishing links between priority-setting processes for land release operation and development actors to support survivors and indirect victims;
11. ensure that explosive ordnance risk education (EORE) sessions are inclusive of survivors and other persons with disabilities;
12. monitor the messages on disability inclusion to ensure they are presented in EORE sessions in accessible formats, and promote positive knowledge, attitudes, and practices towards persons with disabilities;
13. promote inclusive and non-discriminatory employment law, employment opportunities and hiring practices to ensure that survivors and persons with disabilities have access to income-generating jobs (including in the HMA sector);
14. support the adoption and implementation of laws that promote and protect the rights of survivors, and address the needs of EO victims; and

[43] Ensuring inclusion and participation of victims in decision-making processes (throughout the project cycle of programmes from planning to evaluation) at all levels regarding law, policy, and programmes that affect them is outlined as an objective in the Oslo Action Plan.

15. refer victims of EO-related violations of international human rights or of serious violations of international humanitarian law to relevant authorities that can support them to purse effective remedies against those responsible.

(IMAS 13.10 5.1.2) CMAC (the NMAC) should:

1. Identify and refer EO victims to services through the provision of information of services in coordination with the CMAA;
2. communicate information to stakeholders in rural economic development and local authorities - in accessible formats and in line with data protection regulations – in an effort to facilitate access to services;
3. communicate the locations where emergency medical care should be improved to the CMAA, and communicate the needs of people injured, survivors, and indirect victims to donors, the CMAA, and relevant national bodies to engage multi-stakeholder support; and
4. implement community awareness activities on their rights of victims and persons with disabilities, and develop programmes to ensure that victims know their rights.

(IMAS 13.10 5.2) Mine action operators should:

1. Inform the CMAA of all VA-specific efforts;
2. Collect disaggregated data on victims and share with the CMAA and other relevant national bodies (e.g. MoH, MoSVY), ensuring that data protection regulations are followed;
3. collect data on relevant services in the area of operations to help the CMAA to map services and build a directory;
4. support the dissemination of the directory and of accessible information on available services to EO victims in collaboration with the CMAA and other relevant bodies;
5. identify and facilitate access to emergency care for those injured by EO and other persons in cooperation with the Ministry of Health and provide transport if necessary; and
6. communicate the locations where emergency care should be reinforced to the MoH and the CMAA and communicate the needs of people affected by EO to donors, the CMAA and other relevant actors to engage multi-stakeholder support.

Mine Action Operators who receive earmarked funding to deliver VA services should:

7. Inform the CMAA and affected communities of their VA services and available support;
8. ensure that their VA services comply with national and international standards, conventions, and policies on health, education, and socioeconomic policies;
9. ensure that implementing partners (IPs) are registered with the relevant government ministries or bodies in charge of verifying that they are competent, suitably trained, qualified, and quipped, and
10. ensure that survivors and their representative entities are consulted, participate, and are included in VA services they undertake.

(IMAS 13.10 5.3) Survivor organisations and their representative entities should:

1. guarantee and advocate for participatory principles;
2. extend institutional memory of local best practices;
3. ensure that VA and disabilities are understood at all levels of mine action;
    a. Survivor organisations should be consulted throughout the project cycle of victim assistance and disability programmes and policy through the appropriate national mechanisms

Additionally, survivor organisations should conduct and coordinate activities cohesive with national strategic mine action and disability developments. See IMAS 13.10 (2023) page 7 for a list of possible responsibilities and activities of survivor organisations.

The United Nations (UN) Policy on Victim Assistance Adapted to Cambodia

As outlined in the APMBC Oslo Action Plan, the international community should provide Cambodia with the human, financial and material capacity to carry out their obligations under the Convention where necessary. As a symbol of international support in the mine action sector and a focal point of mine action standards, law, and guidelines, the UN has a specific responsibly to ensure the proper provision of VA in Cambodia. Accordingly, the following has been adapted from the United Nations Policy on Victim Assistance in Mine Action (2016). To see a more detailed list of responsibilities of the UN regarding country-level support to victim assistance refer directly to the document, Section G (pp. 7-9).

(31-34) Advocacy for the inclusion of EO victims in programmes to benefit persons with disabilities, and national adherence to international conventions. Where appropriate, assist resource mobilisation efforts in support of VA. Encourage the hiring of EO victims in UN bodies.

(35-37) In cooperation with the CMAA, the relevant UN agencies should collect and analyse disaggregated data (including a needs assessment and service referrals) to provide a baseline for effective programming. This data should be integrated with relevant health- and disability-related reporting.

(38-40) The UN should support the capacity enhancement of the capacities of public systems and services in Cambodia, as well as local communities, to ensure that VA services remain accessible in the long term. The United Nations may provide expertise for the provision of capacity-enhancement assistance to integrate VA for EO victims into national policy frameworks on healthcare, social services, and disability-inclusive development. The United Nations may support governments in the development of national plans and budgets for VA.

(41) The UN monitoring and evaluation mechanisms should determine whether:

a. there is the collection, analysis and dissemination of disaggregated data that is inclusive of EO victims;
b. Cambodia provides medical care, physical and sensory rehabilitation, psychosocial support, education and skills training and income-earning opportunities and to provide those services to all, regardless of gender, age, or socio-economic status to ensure the proper psychosocial support, social inclusion, economic reintegration and protection of victims;
c. there has been sufficient budget within broader frameworks to ensure that services address the rights of persons with disabilities; and
d. Cambodia has adopted and implemented a disability policy and plan of action that incorporated all aspects of victim assistance.

The Convention on the Rights of Persons with Disabilities Applied to Victim Assistance Services

To emphasise the responsibility of stakeholders to EO victims in Cambodia, the rights of persons with disabilities - one of the most comprehensive rights-based documents highly relevant to EO victims – has been outlined below within the context of the VA services described. It is important to remember that Cambodia, and many of the APMBC members that donate to mine action in Cambodia have signed and ratified this treaty.

Cross-Cutting Responsibilities and Activities

Article 4: General Obligations

1. Sates Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, States Parties undertake:

(a) To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention;

(b) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;

(c) To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes;

(d) To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention;

(e) To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise;

(f) To undertake or promote research and development of universally designed goods, services, equipment and facilities, as defined in article 2 of the present Convention, which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design in the development of standards and guidelines;

(g) To undertake or promote research and development of, and to promote the availability and use of new technologies, including information and communications technologies, mobility aids, devices and assistive technologies, suitable for persons with disabilities, giving priority to technologies at an affordable cost;

(h) To provide accessible information to persons with disabilities about mobility aids, devices and assistive technologies, including new technologies, as well as other forms of assistance, support services and facilities;

(i) To promote the training of professionals and staff working with persons with disabilities in the rights recognized in the present Convention so as to better provide the assistance and services guaranteed by those rights.

2. With regard to economic, social and cultural rights, each State Party undertakes to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realization of these rights, without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law.

3. In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.

4. Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of persons with disabilities and which may be contained in the law of a State Party or international law in force for that State. There shall be no restriction upon or derogation from any of the
human rights and fundamental freedoms recognized or existing in any State Party to the present Convention pursuant to law, conventions, regulation or custom on the pretext that the present Convention does not recognize such rights or freedoms or that it recognizes them to a lesser extent.

5. The provisions of the present Convention shall extend to all parts of federal States without any limitations or exceptions.

Article 7, Paragraph 1: Children with Disabilities

States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.

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;
   (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;
   (c) To promote awareness of the capabilities and contributions of persons with disabilities.

2. Measures to this end include:
   (a) Initiating and maintaining effective public awareness campaigns designed:
      (i) To nurture receptiveness to the rights of persons with disabilities;
      (ii) To promote positive perceptions and greater social awareness
      towards persons with disabilities;
      (iii) To promote recognition of the skills, merits and abilities of persons with disabilities, and of their contributions to the workplace and the labour market;
   (b) Fostering at all levels of the education system, including in all children from an early age, an attitude of respect for the rights of persons with disabilities;
   (c) Encouraging all organs of the media to portray persons with disabilities in a manner consistent with the purpose of the present Convention;
   (d) Promoting awareness-training programmes regarding persons with disabilities and the rights of persons with disabilities.

Article 9: Accessibility

To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas.

These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

(a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
(b) Information, communications and other services, including electronic services and emergency services.

States Parties shall also take appropriate measures:

(a) To develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
(b) To ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;
(c) To provide training for stakeholders on accessibility issues facing persons with disabilities;
(d) To provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;
(e) To provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;
(f) To promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
(g) To promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;
(h) To promote the design, development, production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum cost.

Article 19: Living independently and being included within the community

States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

Article 20: Personal Mobility

States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:

(a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;
(b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;
(c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;

(d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

Article 31 of the CRPD - Statistics and data collection

1. States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall:

(a) Comply with legally established safeguards, including legislation on data protection, to ensure confidentiality and respect for the privacy of persons with disabilities;

(b) Comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics.

2. The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights.

3. States Parties shall assume responsibility for the dissemination of these statistics and ensure their accessibility to persons with disabilities and others.

Medical Care and Rehabilitation

Article 25 of the CRPD: Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Mental Health and Psychosocial Support

Article 16, paragraph 4 of the CRPD: Freedom from exploitation, violence and abuse

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

Article 26 of the CRPD: Habilitation and Rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
(b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Socioeconomic Inclusion

Article 24 of the CRPD: Education

1. States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and lifelong learning directed to:

(a) The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;
(b) The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;
(c) Enabling persons with disabilities to participate effectively in a free society.

2. In realizing this right, States Parties shall ensure that:

(a) Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;
(b) Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;
(c) Reasonable accommodation of the individual's requirements is provided;
(d) Persons with disabilities receive the support required, within the general education system, to facilitate their effective education;
(e) Effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion.

3. States Parties shall enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. To this end, States Parties shall take appropriate measures, including:

(a) Facilitating the learning of Braille, alternative script, augmentative and alternative modes, means and formats of communication and orientation and mobility skills, and facilitating peer support and mentoring;

(b) Facilitating the learning of sign language and the promotion of the linguistic identity of the deaf community;

(c) Ensuring that the education of persons, and in particular children, who are blind, deaf or deafblind, is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximize academic and social development.

4. In order to help ensure the realization of this right, States Parties shall take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities.

5. States Parties shall ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination and on an equal basis with others. To this end, States Parties shall ensure that reasonable accommodation is provided to persons with disabilities.

Article 27 of the CRPD: Work and Employment

1. States Parties recognize the right of persons with disabilities to work on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard and promote the realization of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps, including through legislation, to, inter alia:

(a) Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions;

(b) Protect the rights of persons with disabilities, on an equal basis with others, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances;

(c) Ensure that persons with disabilities are able to exercise their labour and trade union rights on an equal basis with others;

(d) Enable persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training;

(e) Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment;

(f) Promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business;

(g) Employ persons with disabilities in the public sector;

(h) Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures;

(i) Ensure that reasonable accommodation is provided to persons with disabilities in the workplace;

(j) Promote the acquisition by persons with disabilities of work experience in the open labour market;

(k) Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.

2. States Parties shall ensure that persons with disabilities are not held in slavery or in servitude, and are protected, on an equal basis with others, from forced or compulsory labour.

Article 28 of the CRPD: Adequate standard of living and social protection

1. States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.

2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:

(a) To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs;
(b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes;
(c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counselling, financial assistance and respite care;
(d) To ensure access by persons with disabilities to public housing programmes;
(e) To ensure equal access by persons with disabilities to retirement benefits and programmes.

Article 29 - Participation in political and public life

States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, and shall undertake to:

(a) Ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives, including the right and opportunity for persons with disabilities to vote and be elected, inter alia, by:
    (i) Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use;
    (ii) Protecting the right of persons with disabilities to vote by secret ballot in elections and public referendums without intimidation, and to stand for elections, to effectively hold office and perform all public functions at all levels of government, facilitating the use of assistive and new technologies where appropriate;
    (iii) Guaranteeing the free expression of the will of persons with disabilities as electors and to this end, where necessary, at their request, allowing assistance in voting by a person of their own choice;
(b) Promote actively an environment in which persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others, and encourage their participation in public affairs, including:
    (i) Participation in non-governmental organizations and associations concerned with the public and political life of the country, and in the activities and administration of political parties;
    (ii) Forming and joining organizations of persons with disabilities to represent persons with disabilities at international, national, regional and local levels.

Article 30 - Participation in cultural life, recreation, leisure and sport

1. States Parties recognize the right of persons with disabilities to take part on an equal basis with others in cultural life, and shall take all appropriate measures to ensure that persons with disabilities:
   (a) Enjoy access to cultural materials in accessible formats;
   (b) Enjoy access to television programmes, films, theatre and other cultural activities, in accessible formats;
   (c) Enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance.
2. States Parties shall take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society.

3. States Parties shall take all appropriate steps, in accordance with international law, to ensure that laws protecting intellectual property rights do not constitute an unreasonable or discriminatory barrier to access by persons with disabilities to cultural materials.

4. Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture.
5. With a view to enabling persons with disabilities to participate on an equal basis with others in recreational, leisure and sporting activities, States Parties shall take appropriate measures:
   (a) To encourage and promote the participation, to the fullest extent possible, of persons with disabilities in mainstream sporting activities at all levels;
   (b) To ensure that persons with disabilities have an opportunity to organize, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources;
   (c) To ensure that persons with disabilities have access to sporting, recreational and tourism venues;
   (d) To ensure that children with disabilities have equal access with other children to participation in play, recreation and leisure and sporting activities, including those activities in the school system;
   (e) To ensure that persons with disabilities have access to services from those involved in the organization of recreational, tourism, leisure and sporting activities.

Situations of Risk and Humanitarian Emergencies

Article 11 - Situations of risk and humanitarian emergencies

States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.

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